PUBLIC ADMINISTRATION AND PRIVATISATION PROGRAMMES: A CASE STUDY OF THE CONTRACTING-OUT OF MANAGEMENT IN SAUDI ARABIA

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Declaration

No portion of this work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institution of learning.

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Abstract

The aim of this study is to identify and evaluate three key inter-related tensions concerning how public sector hospitals in Saudi Arabia should be managed: by medical staff or by managers/administrators; by Saudi nationals or by expatriates; by an in-house management team or by a contracted-out management team.

This study examines some specific aspects of public-sector administration: the roles of public-sector management; economic and political policy towards public-sector management, and the development and implementation of public-sector management. Theoretical literature from around the world is reviewed concerning some of the processes involved in economic development, including the movement of existing organisations from the private into the public sector (nationalisation); the movement of existing organisations from the public into the private sector (privatisation); the movement of selected parts of a public-sector organisation into the private sector (contracting-out); the need of developing countries to use public ownership as a means of 'pump-priming'; the use by developing countries of foreign private-sector expertise, particularly in terms of contracting out the management of public-sector organisations; and the desire of developing countries to 'indigenise' the management of both private-sector and public-sector organisations, particularly through the use of public-sector in-house management.

Taking as a detailed case study the public health sector in Saudi Arabia, the thesis examines the efficiency and effectiveness of contracted-out (private-sector) management against in-house (public-sector) management of public-sector hospitals. A number of management performance elements are identified: planning, organising, directing and controlling. An evaluation of management effectiveness is given, along with employee satisfaction, to determine whether public-sector hospitals are best operated by utilising private-sector (contracted-out) or public-sector (in-house) management for all hospital services or only for selected services in an attempt to improve efficiency, to reduce operational costs, and for the best utilisation of manpower, technology and financial resources.

Dedication

I dedicate this work to: King Abdul Aziz who united the country, the Kingdom of Saudi Arabia, the President of the National Guard who sponsored the first degree scholarship and the King Khalid Military Academy, who sponsored the scholarship of my post-graduate studies, the director of the Academy, His Royal Highness Prince Mut'ib Bin Abdullah Bin Abdul-Aziz, the Assistant director, Brigadier General Essa Al-Rasheed, Sultan T. Al-Harthi everlasting consideration, and Dr. Abdulrahman Al-Subait, the Academy General directors, teaching staff, managers, and to all of those who extended their help.

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Glossary

.	Data not applicable
...	Data not available or incomplete
—	Zero
F	Female
M	Male
T	Total
NS	Non Saudi
No.	Number
S	Saudi
SR	Saudi Riyals (National Currency)

Al	Always
Mo	Mostly
So	Sometime
Se	Seldom
Ne	Never
Mi	Missing
H_0	Statement of the null hypothesis
H_1	Statement of the alternative hypothesis

AFMS	Armed Forces Medical Services
GCC	Gulf Cooperation Council
GDP	Gross Domestic Product
GOSI	General Organization for Social Insurance
GPGE	General Presidency for Girls Education
GPYW	General Presidency for Youth Welfare
IPA	Institute of Public Administration
KACST	King Abdul Aziz City for Science and Technology
KFH	King Fahad Hospital
KFSH&RC	King Faisal Specialist Hospital& Research Center
KSA	Kingdom of Saudi Arabia
MIMS	Ministry of Interior Medical Service
MOAW	Ministry of Agriculture and Water
MOC	Ministry of Communication
MOE	Ministry of Education
MOH	Ministry of Health
MOI	Ministry of Information
MOP	Ministry of Planning
PHC	Primary Health Center
PIF	Public Investment Fund
SAAB	Saudi Arabian Agriculture Bank
SABIC	Saudi Arabian Basic Industries Corporation
SANG	Saudi Arabian National Guard
SFH	Security Force Hospital
SRCS	Saudi Red Crescent Society

Chapter One

Introduction

1.0 Introduction

In the Kingdom of Saudi Arabia (KSA), over the past decade, public administration policy has been concerned with reducing dependence on contracted-out management teams, and replacing them with in-house management teams. This shift has been undertaken despite a dearth of detailed studies on the effect and efficiency of previous experiments in contracting out management in Saudi Arabia. The absence of studies gave impetus to this thesis, as it is important to explore the arguments, advantages and disadvantages of contracted-out management versus in-house management of public hospitals and services in Saudi Arabia (Chapter 2, section 2.5).

The development of public administration and public management is a continuous process. It takes a great deal of effort, over a long period of time, to train people effectively in the skills necessary to run their country/organisation efficiently. Professional administrators/managers are trained to manage public/private organisations efficiently. It makes sense to select a person from the appropriate profession, to place that person in the right job, to offer opportunities to gain knowledge and experience and enable them to mature in a way which will be in compatible with their own needs as well as those of their country, office, department, and organisation (Freeman-Bell and Balkwill, 1996).

In a study undertaken by the World Bank, Shaikh (1997) suggests that an alternative solution to the inefficiency of public administration and the management of public organisations found in many countries is to instigate a privatisation programme as, he maintains, such a programme would increase the efficiency of a public organisation's management and the operation of all its services. This would lead to the transfer of all or some government sectors goods and/or services into private ownership, or else provide opportunities for contracting-out to the private sector services currently in the public sector (Hartlely and Huby, ed., Kay, Mayer, and Thompson, 1986; Al-Munief, 1995; Al-Reshaid, 1996; Muhana, 1998). However, none of the studies undertaken concerned contracted-out management in the public health management and services in Saudi Arabia.

Privatisation takes many forms, and will be discussed fully in Chapter 2 section 2.1. It involves transferring services formerly provided in-house to the private sector (contracted firms). The aim is to enhance the efficiency and effectiveness of the management performance of public organisations. It is asserted that privatisation programmes aim to establish and develop private sector competition for better management efficiency and effectiveness, provide the national economy with better service, increase national recruitment by the private sector, reduce unemployment and bureaucracy, expand the proportion of social services responsibility taken by the private sector, and limit the vast responsibilities of government over the state management of services (Al-Munief, 1995; Al-Reshaid, 1996; Muhana, 1998). This assertion is contested here in this thesis, on the grounds that the success of privatisation programmes varies from one country to another, depending on several factors including whether they are undergoing constant rapid change, such as social

cultural; the political and economic system; and technological development (ibid). These have a great impact on both the public and private sector management's basic elements such as planning, organising, directing and controlling, which require continuous process of re-engineering to maintain the management efficiency and effectiveness (Al-Sultan, 1998).

In short, it is argued that the success of privatisation programmes cannot be universalised because what may succeed in one country may not succeed in the other (Hickson and Pugh, 1995:12-14, Al-Munief, 1995). Hickson and Pugh (1995) argued that what matters in understanding the management in a particular country is not primarily its distinctive culture, but first and foremost worldwide technical factors such as the level of economic development, foreign investment, technological sophistication and access to global communications and markets. Even within one country, for instance the United States, some attempts to contract-out management and services have been successful, whereas others have failed (Cook, 1990).

> *In the 1970s/1980s the needs and expectations of Saudis, which set the standards for economic development, were so urgent and expensive that the Saudi government has had to assume the leading and dominant role (not by choice, but out of obligation). This primacy of government in the economic development process is taken for granted in Saudi Arabia. The situation was definitely different in the case of Western European societies and their offshoots (Nehme, 1995:157).*

Therefore, this study aims to investigate contracted-out management in Saudi Arabia to find out which public administration policy is the most beneficial for managing

public health organisations in Saudi Arabia.

This introductory chapter provides a statement of the problem faced by Saudi Arabia in framing its public administration policy for its public hospital management. It outlines the importance and states the aims of this study and the research hypothesis. The second chapter considers literature relevant to the role, objectives and the basic function of public administration, public hospital management, private management and contracted-out management. It examines the arguments in the literature for and against the efficiency of contracted-out and in-house management. Chapter Three considers the geographical and economic background to Saudi Arabia. The fourth chapter focuses on Saudi public administration and private sector developments, and the reasoning behind contracted-out public health management. Chapter Five discusses the methodology used for collecting the relevant data, and the methodological tools used for analysing the data. Chapter Six analyses and discusses the collected data. The seventh chapter discusses the public hospital staff interviewees' responses regarding their opinion of the efficiency and effectiveness of each management system. Chapter Eight draws conclusions from the study, and suggests material for future research.

1.1 Statement of the problem

The past two decades have witnessed dramatic changes throughout the world in the field of public administration. Whilst the reasons for these changes are various, the most important is population growth, which in turn, demands more expenditure on services such as education and health. These changes have brought to the fore issues of the effectiveness and efficiency of public organisations, and deemed these issues

vital in the evaluation of any public or private administration system. In this connection, Ridley (1996) argued that the 1980s could be described as a tumultuous decade for bureaucracies across the developed world as governments faced new financial problems and sought to limit public expenditure. Economic recession, and the apparent end of growth, meant limits had to be placed on public expenditure, due to voter resistance to increased taxation. However, government costs continued to rise in many fields for socio-demographic reasons such as pensions, health, education and other public services. It came to be seen as vital to improve the efficiency and effectiveness of the management of public, as well as private-sector, organisations.

Solutions to these economic problems, in the form of management tools, were proposed and found favour: 'management by objectives', 'cost-benefit analysis', 'total quality management', 'market testing', 'performance related pay', 'value for money'. These practices derive their importance from the fact that they are tools of the management profession that ensure effectiveness and efficiency, and, more importantly, the need to hold individuals in the organisation accountable. It was seen that one way to achieve these aims is to have the private sector run public service organisations as commercial businesses. From this idea sprang the political policy of 'privatisation/marketisation', that is, turning over parts (or all) of public sector organisations to the private sector, by means of, for example, franchise, or ownership.

The rapid diversification of the economic base of Saudi Arabia has been made possible by public administration reform, in which public organisations have made use of contracted-out management, and, also, by use of natural resource endowments

and employment of skilled expatriate workers. The challenge ahead is to devise a recruitment, selection, training and placement system for Saudi nationals that will progressively reduce the dependence on expatriate labour without producing a serious loss of competitiveness or drop in economic efficiency (Sixth Five Year Development Plan, 1995-2000: 92).

In view of rapid growth in the number of public health organisations and new clinical services, the excessive utilisation of contracted-out management services risks wasting resources, and needs to be better managed through in-house management (Pincock, 1998).

The author of this thesis possesses the necessary credentials for understanding research into the problems being experienced in the Saudi public hospital management, having worked for four years in a major health organisations: King Faisal Specialist Hospital and Research Centre (KFSH&RC)[1], and later, due to being academically qualified in Business Administration lecturing, in public administration at the King Khalid Military Academy. This background provided the researcher with a good working knowledge of hospital management and the problems it faced, and was of considerable help in conducting the necessary fieldwork.

[1]This is one of the largest and most modern of the government's specialist hospitals, which was, formally, established managed and operated by the private sector, and later transferred to in-house management for all of its services.

1.2 Research aims

This study has three aims:

(1) to identify, in general, the advantages and disadvantages of contracted-out management and in-house management;

(2) to assess the efficiency and effectiveness of contracted-out management and in-house management in Saudi Arabia;

(3) to suggest, based on the findings, an efficient and effective public administration policy for public hospital management.

Therefore, this study could prove invaluable for formulating public administration policies regarding the in-house management of public hospitals in Saudi Arabia, as the study should aid decision making not only for improving management efficiency and effectiveness but also for the growth of the national economy. This study will also contribute towards the development of public administration policy so as to minimise the dependence on expatriates, to develop national manpower and the achievement of the Five Year Development Plans' objectives of instituting a Saudisation programme.

1.3 The importance of the study

Each country has its distinct culture, financial constraints, and its peculiar infrastructure developments, which have an impact on the management of public and private organisations and the constitution of the workforce and, thus, productivity. As stressed above what appears successful or unsuccessful in one country may not be so

in another. Therefore, in view of recent of expansion of industrialisation, founded on the import of foreign labour and foreign management, techniques and personnel, changes found beneficial elsewhere may not be found to be so beneficial to Saudi Arabia.

The rapid diversification of the economic base of Saudi Arabia has been made possible by revenue from the country's oil resources (see Chapter 3) and by contracting-out the necessary work to expatriate firms and individuals whose skills were not in ready supply in the country. This, also, led to the development of the country's administration not only of its public organisation services but also of local private firms who contracted foreign workers to undertake work for which there were too few able or willing local people. However, economic pressures presented Saudi Arabia, like so many other countries, with the challenge of improving the efficiency and effectiveness of its public administration. Factors leading to the reform of bureaucracy are more complex and combine differently in different countries (Ridley, 1996). Development of new methods of public management were seen to be possible through improvements in the managerial functions of planning, organising, directing and controlling, in its practical implementation of recruitment, selection, policy, procedures, training and managerial development. This would progressively reduce the dependence on expatriate labour without producing a serious loss of competitiveness or drop in economic efficiency, in order to comply with the Saudi public administration policy.

Contracting-out of management services was necessary at the start of Saudi Arabia's industrial boom because, as stated earlier, there was insufficient expertise in the

country. Contracted out management, however, is not problem-free. International studies undertaken by economists and others (Hannagan, 1995; Prager, 1997; Pincock, 1998) show that contracting-out itself is costly, so costs must be considered prior to deciding in favour of external suppler. These costs include:

1. administrative and legal costs i.e. specifying the terms of the transaction;

2. arranging for inspections;

3. determining and implementing a contract bidding competition;

4. negotiating loose ends, even before the contract takes effect;

5. litigation by losing parties;

6. project-initiation delays;

7. monitoring the contract;

8. quality control; and

9. dispute resolution.

The organisation putting out tenders must anticipate the possibility of unsatisfactory contractor performance and expect additional costs and delays if it employs another contractor or takes over the privatised operation itself.

The dramatic increases in public administration of health organisations and the development of new clinical services, the excessive utilisation of contracted-out management services may lead to a waste of resources, and needs to be better

managed by in-house management (Pincock, 1998).

Whilst the literature on public administration / privatisation programmes is abundant, literature dealing with contracted-out management in developing countries is scarce, and such literature that does exist usually states theories, whereas actual experiences are rarely recorded and difficult to obtain. So this research was undertaken with the desire of providing knowledge of the subject by making a detailed study of the situation in Saudi Arabia, which is a rapidly developing country in terms of its industry, health service and education systems, adding a wider perspective on the subject. The study findings should be particularly helpful to those interested not only in Saudi Arabia, but also in the other countries in formulating new public management policies. Learning and gaining a perspective on public administration and contracted-out management, requires first an understanding of the concept of both privatisation and public health care management functions.

The public administration of Saudi Arabia launched its industrial and social development, including the health service, with the use of expatriate expertise and has continued to rely, to a large extent, on expatriates. This reliance is now considered undesirable, and the government has stated that it wishes to make the country more self-sufficient. This has led to questioning which type of management better fulfils the role: contracted-out management or in-house management (Al-Nughimshi, 1997).

1.4 Aims of the study

When this study was undertaken its aims, as stated earlier, had to be based on an

awareness of the problems faced by public health management using contracted-out management services, and not only in Saudi Arabia but, also, elsewhere so as to place the situation in Saudi Arabia within an international framework.

In order to achieve the aims, this study presents evidence, gathered from fieldwork, regarding the effectiveness and efficiency of contracted-out management of public hospitals in Saudi Arabia as part of the public administration policy of the country. Questionnaires and interviews were administered to gather the relevant data (Chapters 6 and 7). Chapters 2 and 4 consider existing literature regarding public administration and privatisation programmes, and form a review of international experience in this regard.

1.5 Research hypotheses

Two hypotheses will be tested in this thesis. They are:

(1) There is no significant difference in management efficiency and effectiveness when the management is contracted-out or when it is managed in-house in the case of the public health sector's hospital administration in Saudi Arabia.

(2) Hospital staff support contracted-out management irrespective of their educational background and professional position, medical staff and nationality.

1.5.1 Hypothesis 1

To examine this contention the functions of management will be analysed for both types of management to see whether there is a difference in the public or private

sector's effectiveness of the management procedures.

To survive and prosper, organisations must implement the most efficient system of effective management, employ skilled, proficient managers, and develop technical needs regardless of the traditional cultural practices of favouring certain people (Hickson and Pugh, 1995). Even though a country such as Saudi Arabia is comparatively wealthy, economic efficiency has to be taken into consideration as both health and education have ever-extending needs which can and do threaten a country's economic resources (Hannagan, 1995).

Therefore, in this thesis, the implementation of the following management basic functions in Saudi hospitals' management will be examined using a specially designed questionnaire (Chapter 6) and supplemented by interviews (Chapter 7) analysed separately so as to determine the attitude of individuals employed in both contracted-out and in-house managed hospitals' systems. From this point of view, the proper implementation of management function system can lead to the most effective and efficient management style, and therefore, in this thesis, the implementation of the following management basic functions will be examined. These functions include planning, organising, directing and controlling, and also promoting job satisfaction;

1. Planning

Devising a scheme for accomplishing a purpose, setting clear objectives for the organisation, work procedures, plans of new services, health education, written management instructions, job-descriptions for selecting manpower, retirement scheme, types of equipment and future services for an expected planned period to suit

the organisational short and long term planning periods.

2. Organising

Co-ordinating and preparing for activities so as to achieve objectives efficiently. To modify procedures of operation, i.e. job description, national staff qualification, and the implementation of staff training and development programme.

3 Directing

To point out the proper course: to superintend the planned activity so as to achieve its aims i.e. cost awareness, right decision at a reasonable time, simplifying work procedures, problem solving, rewards and good communication.

4. Controlling

Checking, evaluating and making correction as and when required, to bringing performance in line with the actual plan, i.e. Total Quality Management System for checks, controls and performance improvement.

5. Promoting Staff Satisfaction

In order for any organisations management to run successfully, the staff has to be aware of the aims and objectives of the organisation: to work in harmony and to promote staff satisfaction: to have job stability and most of all, to feel that they are an essential part of the organisation and that their problems, needs and suggestions for improving the work situation will be listened to and evaluated by the management (Harvey Jones 1995, Hannagan, 1998).

1.5.2. Hypothesis 2

The second hypothesis is that hospital staff prefer contracted-out to in-house management regardless of their speciality background, of both contracted and in-house managed of Saudi public hospitals.

In order to test this hypothesis, testing the attitudes of both staff in both contracted-out and in-house managed hospitals of the following categories:

1 - higher management positions, i.e. (Directors and Senior Managers);

2 – non-medical staff;

3 - medically qualified staff;

4 - educational attainment;

5 - Saudi national, and non-Saudi.

1.6 Summary

This introductory chapter has laid out the purpose of this study, beginning by explaining why the contracting-out of the management of Saudi Arabia's public hospitals was thought to be necessary for efficiency and effectiveness. Saudi Arabia supplemented its small reservoir of health service personnel with expatriates, mainly due to a lack of both skilled personnel and expertise in constructing and running

modern, technically advanced hospitals. After the rapid development of the country and its public administration, the need arose to reduce reliance on expatriates and develop home-grown expertise, for, whilst current oil revenues could meet the country's current needs (Chapters 3 and 4), there was no guarantee that future revenues would remain adequate to meet the needs of ever-expanding health services, if run under its present public administration policy characterised by the slogan: 'free health for all'. Saati (1998) has argued that most of the population should have health insurance, not only to support public hospitals, but also to expand private health care. If Saudi health services are to be run efficiently and effectively without the dependence on expatriate staff, then a management system for public hospitals must be devised to satisfy these needs.

Studies of other countries suggested that private sector management of public sector organisations was a route towards greater efficiency and effectiveness (Muhanna, 1998). Others (Chapter 2), however, were reluctant to accept this view. Therefore, a need arose to discover whether contracted-out management or in-house management of public hospitals was the answer for developing and administrating Saudi public hospitals. Accordingly, it was proposed that a hypothesis should be tested, by seeking the opinions of the staff directly involved in the public hospitals, that there was no difference in the public and private sectors' effectiveness of hospital management procedures.

In view of the fact that promoting job satisfaction is an important function of management (Freeman-Bell, 1996), another hypothesis was put forward for testing which was that the speciality, position or educational background of the staff

involved would determine whether they preferred contracted-out to in-house management.

These hypotheses were tested by use both of the questionnaire and interview techniques conducted by the author. The author, with prior experience of Saudi hospital management, is academically trained in business and public administration.

The aims of the thesis were to discover which system of management considered by the personnel involved, to be most effective and efficient but also to be valuable in aiding the development of the Saudi public hospital management policy makers in the future.

Chapter Two

Public Administration, Hospital Management, Privatisation and Public Health

2. 0 Introduction

For any country to function effectively, both politically and economically, the country must have a relatively stable form of administration. Where a country is small and underdeveloped then its public administration is limited to the extent to which it can provide goods and services for its population. However, with rapidly developing countries, such as Saudi Arabia, public administration becomes more and more complex, due to the variety of goods and services it has to provide within a short time span. The situation is further complicated by the fact that it almost certainly has not the expertise to manage modern technology, for in the past there was no call for experts/specialists in, for example, communications, advanced education and sophisticated medical services. So such governments, in order to develop at a rapid pace, adopted the quick solution of employing foreign experts/specialists as, it was hoped, a temporary measure. Regardless of whether institutions were staffed by nationals or non-nationals, the government had to manage them either directly or indirectly through a system of contracting-out. Once management is contracted-out, government control is weakened. Whether this is a good or bad situation is dependent on the culture of the country and how far the government wishes to be involved internationally.

Efforts will be made to define what is meant by public administration and its role, both in general and, specifically, in the case of Saudi Arabia. This will be followed a discussion on the advantages and disadvantages of privatisation, wholly or partly as in the case of contracted-out management.

2.1 Public administration

Public administration can be defined broadly as the management of public goods and service provision for the public. However, writers such as Waldo (1955), Stanyer and Smith (1976), Greenwood and Wilson (1993) and Muhanna (1998), have argued against attempting to produce a simple, one sentence definition of public administration as they considered it impossible to embrace in so few words the complexities of what is involved in the exercise of public administration.

Analysis of public administration requires a focus on the attributes of public administration, public management and recognition of distinctions between public-sector and private-sector management, and a willingness to consider the relationship between government and a public served by the government.

Public administration uses the management functions of the planning, organising, recruiting, directing, co-ordinating, financing and controlling to co-ordinate the activities of groups or individuals in order to help realise the aims of the activity, and to satisfy their public needs such as social, political and to build an economic

infrastructure (Tahir, 1994; Muhanna, 1998). Therefore, public administration co-ordinates groups and/or individuals in the public sector in line with government policy for utilising public resources to satisfy public needs, but has more political concern than public management (ibid). Effective public administration is, ultimately, dependent on the public purse. The more experts there are in the field of public administration in government, the more effective the government will be in dealing with potential or actual economic crises (Saati, 1984).

There are fundamental problems in identifying the outputs of public sector bodies. As Flynn (1986) points out, in organisations where there is no 'market' for the product or service, or where the notion of a market has limited applicability (e.g. in health, education and social services), imported notions of profitability or other financial ratios will only ever be 'surrogate artificial measures' (p. 393). This is why Self (1993) contends that the application of a market model to public administration is seriously flawed. As described earlier, the tasks of public administration differ in critical respects from any business organisation as they draw on powers of coercion and taxation that have no market parallel. Clients of public administration are not and cannot be 'consumers' in the market sense save in some public enterprises (Self, 1997). The new public management with its new public managers appeared as the result of economic pressures, even in Western Europe. The environmental factors leading to the reform of public administration are more complex and combine differently in different countries (Ridley, 1996).

For a government to be effective its public administrators must be highly skilled in the art of management, as Stanyer and Smith (1976) observe: the main distinguishing

feature of public administration lies in its accountability to the public. However, as will be argued later, the Saudi situation is different from that of the West, as the Saudi government is authoritarian and the country is not a democracy.

Equity is difficult to achieve in some states where personal relationships take precedence over impersonal ones. Administrators of public utilities and other state-controlled institutions ideally are expected to treat members of the public fairly without showing partiality to one at the expense of another. With taxation, for example, where liabilities, allowances, exemptions, etc. are laid down quite precisely in law, it follows that taxpayers in identical circumstances should receive identical treatment. As Stanyer and Smith (1976, p.31) comment, this has important administrative implications 'in that it puts a premium on stability, consistency and accuracy, which are less important values in many private enterprises'.

The distinction between private management and public administration has become even more blurred in recent years by the widespread adoption within the public sector of management tools originally designed for private sector analysis. Management accounting relates to 'outputs' or objects of expenditure, enabling specific programmes or services to be costs to be analysed against benefits and some assessment of value for money to be obtained. This has led to Greenwood and Wilson (1993:15) questioning whether 'public administration is simply private management writ public'.

Satisfying staff and public needs is increasingly difficult to achieve in modern public administration and industrial society where needs and desires are not the same, and

interests of the state and the individual can conflict. Though equity and impartiality are distinctive values of public administration which should be preserved, they become subsidiary values, ranking below the pressure for economy and 'goal achievement'. Moreover, these values are also threatened by the reduced security and capacity for self-management of the bureaucracy (Self, 1997).

In a study undertaken by the World Bank, Shaikh (1997) suggests that an alternative solution to the inefficiency of public administration and the management of public organisation is to instigate a privatisation programme as, he maintains, such a programme would increase the efficiency of a public organisation's management and the operation of all its services. This would lead to the transfer of all or some government sectors goods and/or services into private ownership, or else giving opportunities for contracting-out services in the public sector. However, in privatising public management, those management contracts, leases, or concessions, as methods of privatising management, are particularly beneficial in low-income countries with weak capital markets and banking institutions, limited investor interest and weak regulatory capacity (ibid).

From the above dissection, it becomes clear the nature of public administration when stating that its role is not static, as it now has a more managerial approach which emphasises the efficient use of resources and value for money in public service provision. An important effect of the development of public administration has been to emphasise the *skills* component of practical public administration, raising the question of whether public administration teaching should be skills-based as opposed to knowledge-centred.

In order to manage, public administration needs to plan, to organise, to direct and to monitor the organisation's activities, to face their future challenges by re-engineering the organisation's activities. To develop its resources, a country must educate its potential manpower and institute on-site training so as to gain the necessary expertise (Al-Dogether, 1993). This would set an example in countries where public administration management systems have been extensively developed, the public administration in these countries is able better to satisfy the needs and desires of its social, political and economic needs and desire, and also would be an example for other countries to follow.

Public administration and public management development is a continuous process. It takes a great deal of effort over a long period of time to develop people effectively to have the necessary skills in order run their country /organisation efficiently. Professional administrators / managers could manage public / private organisations efficiently, if the organisations select the right professions of people, place them in the right jobs, offer opportunities to gain knowledge and experience and enable them to mature in a way which will be in compatible with their own needs as well as their country, office, department and organisation (Freeman-Bell and Balkwill, 1996).

2.1.1 Public administration policies in some countries

Public administration policies in some countries have made more significant progress than in others and become more advanced in their organisational methods for satisfying the needs of its people. Any decision to contract-out some aspects of the organisation reflects a desire to balance control and efficiency. This balance is

dependent on such factors as governments' limitation of funds due to the continuing rise of multi-fund government services. Thus, as Ridley (1996) prophesied that new public management with its new public managers would appear as a result of economic pressures.

As a country develops, the size and complexity of public administration can become so vast that it is, consequently, very expensive. Then, what has been termed 'economic sclerosis' sets in, because bureaucracy effectively paralyses the functions of management. For example, the British public administration expanded enormously in the twentieth century, and reached a kind of economic sclerosis in the 1970s. The Thatcher government was committed from 1979 onwards, to 'rolling back the frontiers of the state'. The public sector was required to contract-out services, and many nationalised services and industries were privatised, for example, in the areas of transport, housing and education. This was done in an attempt to cut public expenditure. Britain was not the only country to do this. In Eastern Europe, for example, the dilemma facing the reformers, after fall of effectiveness and efficiency of public administration, was to create an economy free to respond to orthodox strategies for growth. To do this they intervened on gigantic, scale to privatise factories, farms and shops (Hickson and Pugh, 1995). America and Canada were committed to reducing the activities of the state, cutting public services personnel, making what remained more business-like, bringing in businessmen as well as business practice (Ridley, 1996).

In the USA, the situation was different to that in Europe as 'there was no dominant administrative group, and the senior executive service ... was a loose grouping of

officials of similar rank, not a cohesive cadre with a distinctive background and tradition. Consequently administrative politics were seen as revolving around the relations of Federal bureaux supervising agencies, Congressional committees and interest groups (Self, 1997). The emphasis is on decentralised authority and successful administration tends to be seen in financial terms. The American desire to have contracts cut and dried and complete can be offensive to those who place more reliance on establishing personal trust, such as many Arabs and Asians (Hickson and Pugh, 1995). In Canada the situation differs from but is affected by the United States. Public administration in Canada differs from the American pattern by being less overtly competitive in manner, and in an British direction, by being more conservative and perhaps more considerate (ibid).

Organisations in the public sector tend to be of the complex type because socio-political and socio-economic factors, regarding goods and services, impact on their performance-related activities, and they depend on the state operating a stable political administration. By definition, countries with small populations, such as Monaco and Kuwait, have fewer human resources than large countries, and therefore will find it harder to develop a widely diversified, trained and educated indigenous workforce. The financial resources available to countries with small populations, such as Saudi Arabia at the time of its formation, may be much slimmer than those available to large countries, although many exceptions can be cited, such as Monaco, Kuwait, Singapore and the former Hong Kong. Economically under-developed countries tend not to have a widely diversified, trained and educated indigenous workforce. The process of creating that workforce is a key factor in the transition towards economic development. In India and Indonesia, for example, an educational

culture has been developed to embrace microchip and information technologies to the point that the workforce is of world-leading status. For a country to develop economically, by nature a long-term project, the country requires a stable public administration environment served by competent public administration managers.

2.2 The role of administrator / manager

Public administration and public management have had to become business oriented. Public administration is vital, as it comprises a large number of individuals working at various jobs and using different materials and equipment in order to achieve a set goal. In both public and private organisations, if staff have to perform diverse jobs, without adequate instruction or supervision, or not understanding the purpose of their work, there is a danger that they will under-achieve to the detriment of their organisation (Harvey Jones, 1995; Hannagan, 1996, Higan, 1999; Al-Omar, 1999). Hence there is a need of a professional manager, to select professional staff, to set out clear objectives and know how to co-ordinate the activities of the staff and to provide suitable teamwork tools, methods and direction to fulfil the organisation's objectives efficiently.

Chell (1993) has argued that organisational constraints are determined by human resource management policy and practice, which can broadly be termed organisational culture, that is values, beliefs and established practice of the members. Each organisational culture grows from within its business provision type (goods or services), and how it is managed also shapes the organisational culture. Policy and practice within the organisation will develop awareness and sensitivity to personality

development that will enable the organisation to develop methods of increasing employee commitment, motivation and work effectiveness, and the opportunities for the organisational cultural change may be created through the introduction of new technology (ibid). This means the organisation would be in a consistent cultural change that would redesign individual responsibilities to cope with social, political and economical situations. This also will require redesign of organisational objectives and individual goals of work to create qualitatively improved jobs and greater participation and managerial consultation to resolve any technical or personnel relation problems to reach the optimum organisational productivity.

The role of a professional manager is very important for an organisation to have an effective and efficient administration. Whilst some successful organisations remain small, others grow. Larger organisations require more complex policies and practices, increasing the burden on management to control efficiency and effectiveness. This complexity requires that the management has, and utilises, the ability to change the behaviour of employees to attain common goals (Vecchio, 1995). 'Managers with informal power - expert and referent power - have greater capacity to affect the satisfaction and performance of employees, whereas formal power - legitimate, reward, and coercive power - potentially has more impact on immediate behavior' (ibid: 323).

When considering whether organisations should be run by the state or whether they should be turned over to private enterprise, Hickson and Pugh (1995) point out that tensions exist in any organisation. The primary one is to decide what is in the public interest and what is in the private interest. Certain questions need to be considered.

How far should managers or organisations be constrained or directed by some wider public interest? Can private interest be more than self-interest? Does state planning and regulation, in what is conceived of as the public interest, unavoidably take decisions out of the hands of those directly responsible for management and, by taking away decision-making autonomy, remove also the essential initiative?

These questions will be considered in the discussion which follows on public administration and privatisation programme, both in general and in Saudi Arabia in particular. These various methods of public administration reforms have been integrated differently in different countries depending on the country's political, social and economic environmental factors. This would show how far countries have gone in establishing new management posts and appointing people designated as managers; and on the other hand, how far they have focused on the introduction of managerial techniques within the administration generally, retaining established structures rather than reorganising institutions. Therefore, it becomes very important to look at the Saudi of public administration system, structure and culture.

Lord Balogh, an advisor to the British government in the 1960s, attributed Britain's economic decline to a lack of relevant training and managerial specialisation of administrators, and a failure to assign to departmental cost-centre managers' responsibility for securing 'value for money' therefore the Financial Management Initiative, a managerialist initiative launched in May 1982, asserted that 'the public sector has much to gain by the introduction of managerial techniques originated in the private sector' (Greenwood, 1993:141).

2.3 Saudi Arabia's public administration early stage and its development

The historical development of administration in the Kingdom of Saudi Arabia can be divided into three stages:

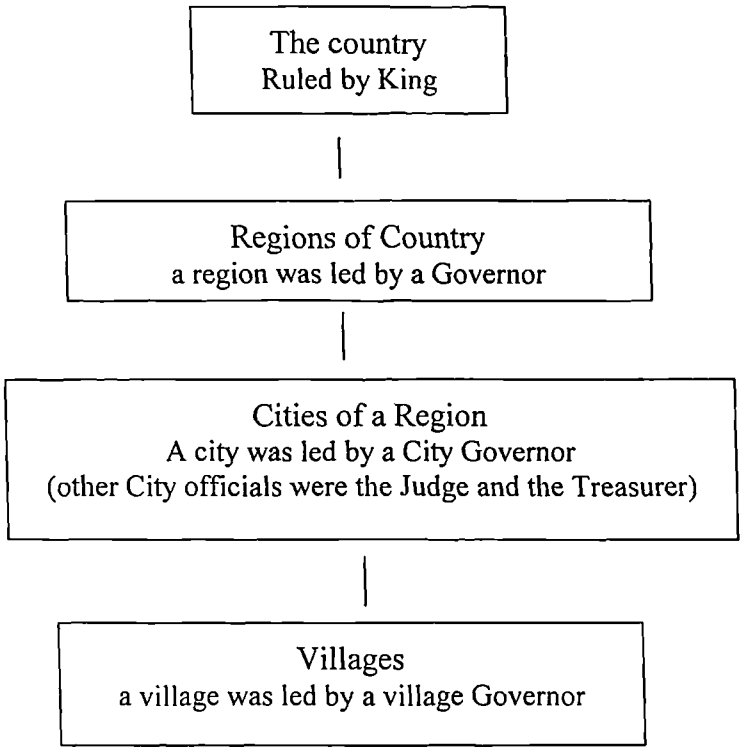
1) The creation of the Kingdom, 1319 to 1372 A.H. (1902 to 1953 C.E.).
2) The building of the central administration, 1373 to 1389 A.H. (1953 to 1969 C.E.).
3) Developing administration, 1390 A.H. to the present (1970 C.E. to the present).

The early stage of the creation of the Kingdom (see above) covered the period from when King Abdulaziz conquered Al-Riyadh to the time of the issuance of the Council of Ministers Statute in 1953 C.E. (Al-Tawail, 1970).

Government administration in Najd, Al-Ahsa, and Asir were examples of local administration in its old and simple fashions (see Fig 2.1). A governor who was directly linked to the King ruled each one of these regions. The governor supervised the city governors who were in charge of a region's cities. The city governors were the Governor, the Judge and the Treasurer. Small villages also had governors who could refer problems to the city governor.

Figure2.1:

Saudi Arabia's Public Administration structure at early stage



Source: Al-Tawil (1995:14)

A slight change in this administrative system happened in the Al-Ahsa region when oil was discovered and the concession was given to the business undertaking known as Saudi ARAMCO. During that period, administration in the three regions of the Kingdom could be described as management of individuals without an attempt to create central administration. Family ties, personal relations, and social customs were the connections in these regions. Hence, administrative regulations and practices as academically known did not exist (ibid.).

The administration in the Al-Hijaz region, however, was to a certain extent more sophisticated. Sharif Hussien, the ruler, created the first government in Al-Hijaz, which consisted of the Ministries of the Interior, Foreign Affairs, War, Education, and Utilities (public works, communications, religious endowment, finance, telegraph, post, and health), and the Supreme Judge. There were also commercial and legal court houses (Al-Otaibi, 1995).

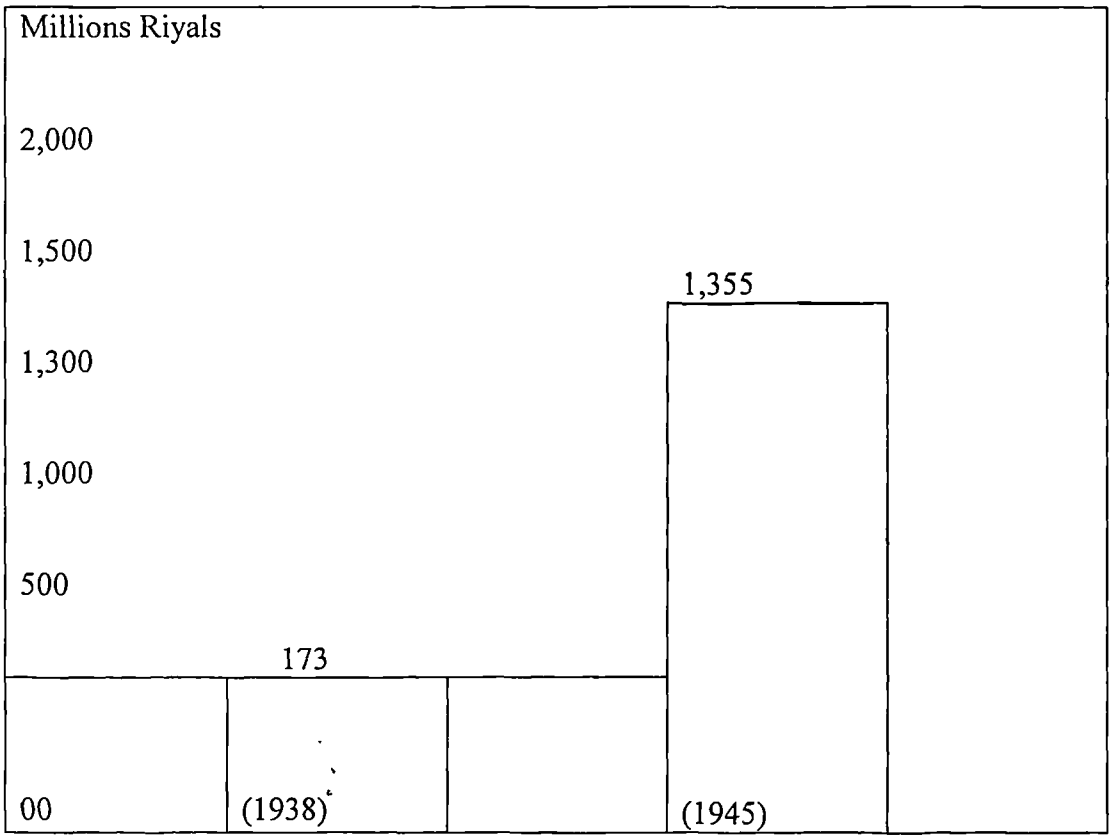
When King Abdulaziz attempted to create a modern administrative organisation for his new country he faced the major problem of a lack of experienced personnel and expertise. The King sought to remedy the situation by hiring some Arabs from Arab countries such as Syria, Lebanon, Egypt, Libya and Iraq to work as executives and consultants, and sought the assistance of some administrators who had worked in Al-Hijaz in Al-Sharif's rule. Then he selected a group of his men to work with the previously mentioned groups in order to achieve what is today known in administration as in-service training, and gave scholarships to young Saudi men to study abroad, initially in Egypt and later in Europe and the USA, in order to prepare them to be leaders for the future.

It should be stated here that King Abdulaziz was the only person controlling the country. None of his brothers, sons, ministers, or governors of regions were allowed to resolve any matters or take any decision concerning internal or foreign affairs without consulting him first either by telegraph, telephone, face to face conversation, or in writing. If he approved it, necessary measures were taken, but if he rejected it, no further action could be taken (Al-Zarkali, 1985).

The economic situation of the new country was less than would be desired. The country was created in a period of an international economic recession after the First World War. Its sources of revenue were from the fees collected from pilgrims. The administrative structure satisfied the country's needs, as the administrative functions in each region were limited to providing basic services and maintaining peace, law, and administrative order. This administrative policy and practice was the administrative polity of Islamic culture. Viola, (1986:xxiv), stated, that 'the political structure of Saudi Arabia is not that of a democracy, nor is it a dictatorship, though it encompasses some elements of both. It is a unique blend of religious law and tribal custom held together by a royal family with strong roots in both religious and tribal history'. Therefore in Saudi Arabia, church and state are one, with the laws of the government and the rulings of the courts based entirely on interpretations of the Koran, (ibid).

While Saudi Arabia was still without schools, radio, newspapers, utilities, or paved roads, King Abdul Aziz Al-Saud signed an agreement with Standard Oil Company of California, granting the American firm exclusive petroleum exploration rights in Saudi Arabia. Later, the Arabian American Oil Company (ARAMCO) was established and commercial quantities of oil were discovered in 1938 (ibid). The number of Saudi employees grew to meet the requirements of the oil company. The first company-operated school was opened in May 1940. From 1945, oil revenues rose sharply (see Table 2.1).

Table 2.1 The Kingdom of Saudi Arabia's early income



Source: Al-Tawil (1995:23)

It soon became clear that the administrative system was incapable of satisfying the new needs. A major change in training procedures was necessary, if the long-range objective of creating a Saudi Arab-American workforce and of progressively eliminating foreign contract employees was to be achieved. But the problem had shifted from training a wholly unskilled and uneducated new recruit into a semi-skilled employee and had become one of training Saudis for very much more complicated and higher-level technical skills and for more sophisticated levels of supervision and lower management, as the Director of the Special Mission, Snyder described to the author Viola (1986:06). The need for trained staff intensified when the government ministries spread throughout the kingdom (Philby, 1955).

These events and incidents led the King seriously to consider establishing a central body to supervise the activities of ministries and government agencies and organisations. On 10 October 1953, Royal Decree No. 4288 was issued, according to which the Council of Ministers was created. This decree is considered the first basic step in creating a modern administration in the Kingdom. In fact, this was the first time that ministries were controlled by a central body which supervised all the affairs of the kingdom (Al-Tawail, 1995).

As countries strive to meet the demands of an expanding economy, the proliferation of government ministries, together with their accompanying civil servants, develops at rapid pace (Hickson and Pugh, 1995; and Al Bishi, 1999). The situation in Saudi Arabia follows the general trend. This can be seen when one compares the situation, shown in Figure 2.1 when the country's administration was in its early stages of development in 1902 with the present day situation (Al-Saud, 2000). However, the situation is likely to develop further. In particular, as the economy expands and the complexities of modern life increases. The Ministry of Health e.g. will, obviously, have to expand as the survival age of the population increases due to better facilities and medical care and, of further advances are made in medical technology. Crozier (1996) and Saati (1999) are among authors who highlight these problems involved in the expansion of State functions in this sphere.

When considering the position of the State with regard to Health spending, Kilksberg, (1999: 14) points out that 'Smart government in the social sphere is not a minimalist or absent government'. This, then, would suggest that he sees the increase in government ministries or ministerial functions to be beneficial to the country's

health care. However, he goes on to say that 'one of the main opportunities for making positive change in the state social sphere in developing countries is provided by the decentralisation of social services to regions and municipalities, (ibid).

Some writers, however, would argue that decentralisation does not reduce bureaucracy but rather it increases, it as ministries need to expand to 'keep track' with those who now attempt to do 'their jobs'. This was the argument put forward by some members of the British Parliament in 1999, when plans were put forward in cabinet for devolution of certain ministerial functions in Britain, in particular health services provision (Hansard, 1999).

The rapid increase in Saudi public administration was made possible by the huge increase in oil revenues, due to the increase in oil production after the Second World War (see Table 2.1). The revenues allowed the government to expand government services to the Saudi people. The government budget of SR 172 million in 1945 had risen nine years later to SR 1,355 million (Table 2.2).

Table 2.2: Saudi Public Administration Development Plan's Revenues

Development Plan	Revenues	Budget year	penditures
First Plan	SR. 5.7	1389-90 (1970)	SR. 6.1
Second Plan	SR. 100.1	1394-95 (1975)	SR. 32
Third Plan	SR. 211.2	1399-1400 (1980)	SR. 188.4
Fourth Plan	SR. 133.6	1405-06 (1985)	SR. 216.4
Fifth Plan	SR. 160	1414-15 (1994)	SR. 160

Revenues from Oil and other: in (SR. billion), Sources: Achievements of the Development Plans, (1996)

Then Saudi public administration had to establish five yearly plans for the development of the country in order to give priorities for basic infrastructure and to monitor and control the country investment of its natural resources. The average annual growth rate of revenues during the first and second plans reached 77.6 percent, and 16.1 percent respectively.

The government's commitment of to accelerate the pace of development in health, education, transportation, communication facilities and later to develop public and private industrial sector and agriculture, the annual growth rate of expenditures rose from 39.4 percent to 42.5 and 2.8 percent during the first and second plans respectively. During the period of the third plan, the oil market witnessed significant changes which affected both the price and total production, thus resulting in a decline in the Kingdoms' revenues. The average annual growth rate was –4.1 percent for the third development plan and this contraction continued into the fourth development plan. This resulted a steady decline in the expenditures. Nevertheless, the completion of major infrastructural projects has equipped Saudi Arabia with modern of health, education, transport, agricultural and industrial facilities. Revenues improved for the fifth development plan, permitting the expansion of development in all aspects of the nation's infrastructure, including the free provision of public health services for everyone living in Saudi Arabia. Rather than being hampered by lack of revenue, the expansion of government services was hampered by the absence of educational institutions that could produce qualified manpower (Sadiq, 1996).

In the 1950s, public administration in Saudi Arabia suffered, in part to the absence of financial and control policies in the country, but mainly due to the Suez Canal crisis which decreased oil revenue. In response, Saudi Arabia sought help from the International Monetary Fund, which, as well as giving support, also imposed obligations on the Saudi government. These obligations included producing an economic development plan, and diversifying government income instead of totally depending on oil revenue as a primary income. For the first time the government was constrained to produce a budget as a tool for financial policy. The government allowed the planned utilisation of the increasing revenues from oil for the purposes of economic and social development which included expansion of the health service by giving impetus to the building of clinics and hospitals (Chapter 3 section 4).

As part of this financial restructuring, the United Nations provided technical assistance to Saudi Arabia by way of experts in various fields: 253 experts were recruited from overseas, in particular from Egypt. They worked on tasks to develop many services and utilities, such as in agriculture, communications, health, social affairs, and aviation, and in many other fields (Report of the Saudi Arabia Central Planning Committee, 1968).

One expert, sent at the Saudi government's request, was Dr Mohammed Tawfiq Ramzi, who was the director of the Institute of Public Administration in Egypt at that time. He spent two months in 1960 studying the administrative system and then issued his report. Among his recommendations was that an institute for public administration should be established to train government personnel and to encourage

the study of public administration through granting scholarships to study this field abroad (Ramzi, 1961).

The government expedited the establishment of a new institution to be known as the Institute of Public Administration. Royal Decree No. 93, 1961 was issued establishing a new public administration institute (Ramzi, ibid.). The next approach by the Saudi government for expertise was to the American Ford Foundation to achieve the goals suggested by the study of Dr Ramzi to develop administration in the Kingdom. This resulted in a series of committees being set up to examine and advise on aspects of public administration. The outcome, from 1970 to the present has lead, among other improvements and innovations, to the establishment of a number of five-year development plans (the most recent being the 6th Five Year Development Plan 1995-2000), so as to establish an orderly framework for development.

The administrative development projects have been supervised and run by national experts, which reveals the great advance that has been made in acquisition of expertise by Saudi nationals. As a result, of dependency on foreign experts and expertise has significantly declined. The Higher Committee for Administrative Reform has become the agency responsible for administrative development affairs in the Kingdom (Al-Tawail, 1995).

Since the start of its oil boom in the 1930s, Saudi Arabia has had to face considerable problems with public administration due to its rapidly developing economy. It has not been easy to find the best balance between investment of oil revenues at home in

expensive agricultural irrigation and diversifying industries, and investment abroad. The lack of experienced personnel, and the absence of companies with knowledge of modern technological developments, forced the government to relinquish some of its control to foreign companies and also to privatisation, whole or partial, of some enterprises (Aba-Namay, 1995).

Over the past decade, public administration in Saudi Arabia has been reducing its dependence on contracted-out management and reverting to in-house management, particularly in the health services. However, there have been no detailed studies of the effect and efficiency of contracted-out management experiments in Saudi Arabia. The shortage of studies gives impetus to this thesis, which concerns the activities of the health services, as it is important to explore the arguments for and against contracted-out hospital management (sections 2.5 and 2.6).

In a study of public administration and the efficiency of the management of public organisations (though not in Saudi Arabia) undertaken study by the World Bank in some other countries of Middle East and Africa, suggests that an alternative solution to the inefficiency found in the public management of some public organisations is to instigate a privatisation programme, which such a programme would increase the efficiency of a public organisation's management and the operation of all its services, Shaikh (1997). This has lead to the transfer of all or some government sectors' goods and/or services into private ownership. However, contracted-out management in Saudi Arabia will be discussed fully below in section 2.6. This basically involves transferring services provided formerly in-house to private sector contracted firms; the aim is to enhance the efficiency and effectiveness of the management

performance of public organisation. It is often held that privatisation programmes in Saudi Arabia aims to establish and develop private sector competition for better management efficiency and effectiveness, provide the national economy with a better service, increases national recruitment, reduces unemployment, has less bureaucracy, increases social services responsibilities by the private sector and limits government responsibilities over the state management of public services (Al-Munief, 1995; Al-Rushaid, 1996; Muhanna, 1998).

The validity of these claims will be contested in this thesis on the grounds that success of privatisation programmes varies from one country to another depending on several factors such as cultural background, political and economic system, stability, resources and technologies (Al-Munief, 1995; Al-Rushaid, 1996; Muhanna, 1998).

It is argued here that the success of privatisation programmes cannot be universalised because what may succeed in one country may not succeed in the other (Hickson and Pugh, 1995). No country is identical in economic conditions, political and natural resources, or in population to Saudi Arabia (Al-Munief, 1995). Nehme (1995:157) noted that

> *A certain amount of the economic development process may take place under private auspices, but in the 1970s/1980s the needs and expectations of Saudis, which set the standards for economic development, were so urgent and expensive that the Saudi government has had to assume the leading and dominant role (not by choice, but out of obligation). This primacy of government in the economic development process is taken for granted in Saudi Arabia. The situation was definitely different in the case of Western European societies and their offshoots.*

They argue that 'what matters in understanding the management in a particular country is not primarily its distinctive culture, but first and foremost worldwide technical factors such as the level of economic development, foreign investment, technological sophistication and access to global communications and markets' (Hickson and Pugh, 1995:278).

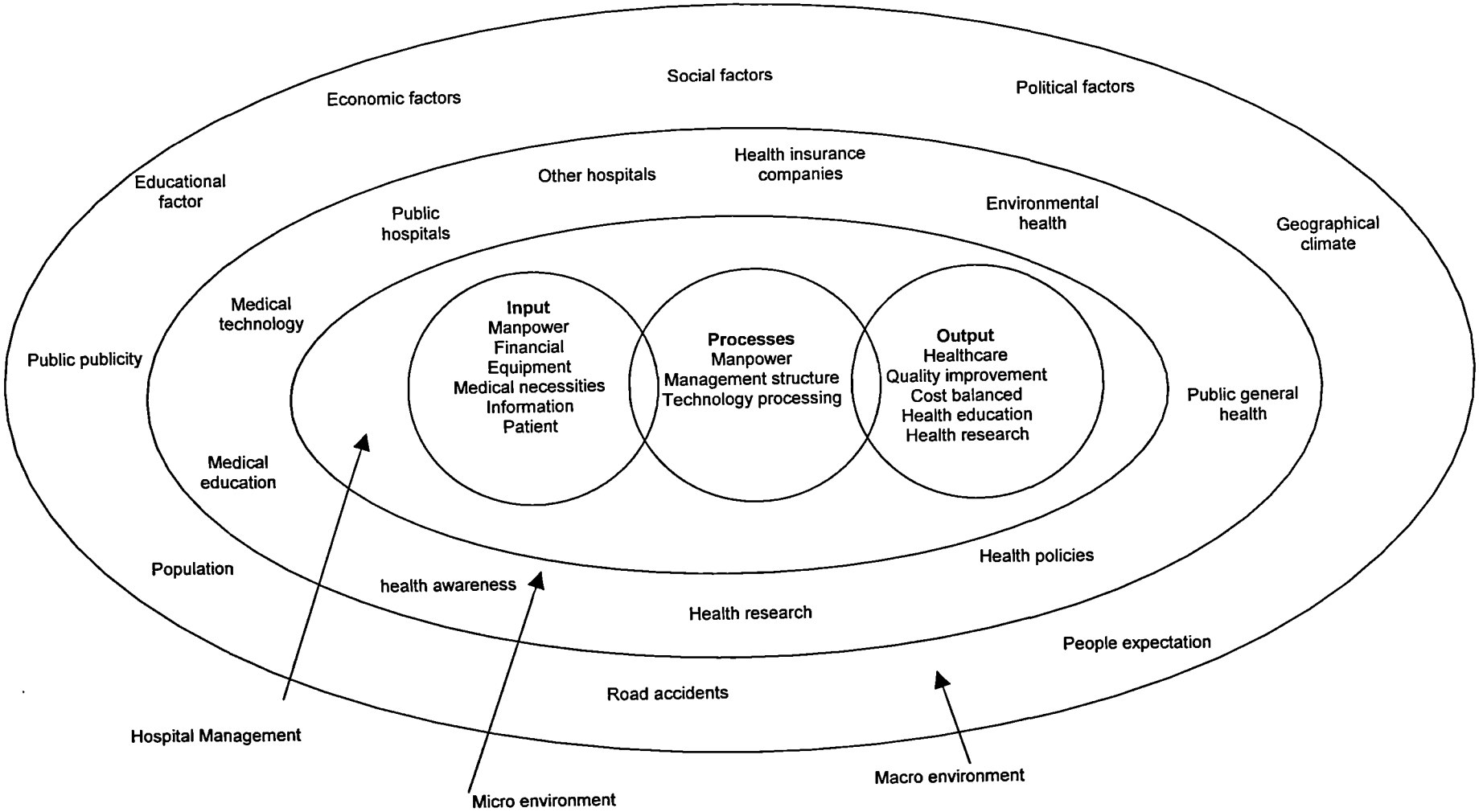
The establishment of public enterprises in the Kingdom as a method of administrative structuring can be perceived as one unique feature of the overall administrative development of the country. However, Abdulrahman (1975) maintains that public enterprises are characteristically assigned tasks that cannot be managed like any other task by governmental apparatus. This is particularly the case with social services, of which the Health Service is a significant part. With health services one is dealing with an undetermined number of recipients (patients) at any one time, where outcomes are uncertain and public desires for treatment and facilities can go beyond those provided by the state. This has led many theorists and others to question whether a government agency run by modern administrative methods is the best solution for medical requirements and that health service hospitals and clinics would be run more effectively if turned over wholly or in part to the private sector.

2.4 Hospital management

Figure 2.2 shows that the hospital management has multi environmental effects on the efficiency and effectiveness is exceedingly complex. At the centre is the management which has to function in relation to its input and required output (Saati, 1999). None of the three intersecting circles is independent. From these circles

radiates the dependencies on the management's policies, that is, where they are put into practice of the interrelated circles, like manpower, finance, equipment, medical necessities, information accessibility and patients. Processes take place for they're to be a successful output of healthcare, quality improvement, cost efficient, health education and health research. The outer circle represents the 'feeders' which are effects the increase demand for healthcare treatments when they increase negatively, for example, the increase in environmental pollution, medical technology, road accidents, population, and the decrease in general public health education, the decrease in health research and health awareness. All these factors in the outer circle are both separate, and at the same time dependent or influenced by each other. Therefore, whether one regards the diagram as representing ever-decreasing circles towards the health management or ever-increasing circles, due to centrifugal forces of the management's policy radiating from its major functions both to cure the sick and preventative medicine, the fact remains that all aspects, illustrated in whatever circle, are affected by each other and the adjacent circle. It is this dependency which makes health care so complex and so costly and, also, shows the necessity of the health ministries interrelating with the various other ministries i.e., which are concerned with the environment, transport and finance. Their co-operation would contribute towards a reduction in the number of people needing health care, by providing a safer environment. *Riyadh Newspaper* (29 May 1999) noted that there were 153,000 road accident involving 28,144 people in one year. The reporter claims that many of these accidents could have been prevented with the enforcement of traffic regulations.

Figure 2.2 Hospital Management and its Environmental effects



Other preventive illnesses, often fatal, are due to lack of enforcement of health restrictions on retailing food and meal provision, (Al-Madinah, 8 October 2000).

2.5 In-house management

In-house management means that the management of an organisation or institution is not under private control but is run by the state. Its managing director is actually a civil servant who is responsible for running the organisation in line with government policy. Such an organisation is funded by the state. Depending on what leeway the managing director is given, he is responsible for employing staff, purchasing supplies and allotting contracts to supply goods or additional services, which cannot be provided in-house by its own personnel. Wage structures (see Appendix VII) and payment of supplies is, usually, not under his/her control but decided by the appropriate government ministry (Hannagan, 1995 and Al-Fawaz, 1998). Therefore, it is usually necessary for him/her to liaise with both the Ministry of Finance and the Ministry of Health.

2.5.1 In-house management of Saudi public hospitals

In order to examine whether a Saudi public hospital managed in-house, the relevant literature is best viewed as responses to certain questions. If there is, as reported in various literature (see above) an increasing tendency in the developed and developing countries to privatise institutions, what reasons can be put forward for Saudi Arabia to go against the trend?

Other questions which various authors have attempted to answer are: Is cost saving to be the main criteria for changing the present private management system to in-house management, and has it proved successful? Has a changeover to in-house management proved successful elsewhere? What benefits apart from cost saving can in-house management provide that cannot be provided by the contracted-out management?

In answer to the first question as to why change is felt necessary, Ogail (1995) saw the main advantages for the in-house management of Saudi hospitals as:

a) security for government sector advancement of the economy by encouraging investment;

b) establishment and development of national abilities;

c) sustained employment for nationals, thus increasing their expertise;

d) increasing technical knowledge so as to reduce the dependence on outsiders;

e) it is cheaper to employ Saudi nationals.

The Saudi government is conscious that the flow of revenue from oil and minerals is not infinite. In the future there may come a time when other countries are not so dependent on Saudi oil, as alternatives may be discovered (Hickson and Pugh, 1995). Therefore, there is a need to reduce cash flow out of the country by, among other ways, reducing foreign labour and imports and 'limit the budget ahead of time' (Ogail and Ammar, 1995: 3). Only training nationals can only overcome the shortage of Saudi technical staff, but, as Al-Nughimshi (1997) pointed out, incentives are necessary in order to persuade nationals to train for the required positions and to relocate. An increased supply of trained local staff would reduce the need to

contract-out the management of the public hospitals belonging to and run by the state.

When the argument in favour of contracted-out management is based on cost alone, then the argument is difficult to sustain in the case of the health services. Several authors, including Robertson (1993), Harvey Jones (1993), and Hannagan (1995), have pointed out that it is not possible to equate the health service with an industry and employ identical methods for increasing its economic efficiency. As Hannagan (1995) contended, there is a human factor involved in medical services and, therefore, one cannot delay or fail to attempt resuscitation on the grounds of cost by claiming that it would save money by not treating potentially hopeless cases.

Therefore, contracting-out could be disruptive to healthcare services and that most medical procedures are complex as it is difficult for contractors to purchase medical services, because there is no 'best way' to provide a service which has so many variants: medical services are not product-specific.

Once contractors (for some services) have contracted the service they no longer have the expertise or knowledge to evaluate the quality of the service provided, as only the contractees have this information. This view provides a strong argument against contracting-out of medical services. The lack of management knowledge and complexities of contracting-out would always present significant risks to public purchases and that specifying adequate contract terms in health has proved difficult for practitioners. Contract breaches are particularly serious when related to health care. A firm carrying out hospital payroll operations might threaten to withdraw

service, thus jeopardising the payment of a payroll and pay cheques. This could, effectively, shut down a hospital. This would not occur in the case of in-house management, which has direct access to funding from the Ministry of Finance.

There are studies, by Arabs, of cases in Saudi Arabia where in-house management has proved to be cost effective. Hussain (1998) quotes that the Ministry of Defence Hospital, Riyadh, which had been self-managed for 15 years, has a predominantly national staff and that it has been so successful in its in-house management, that many people still think that it is using contractors as it is so well run. The National Guard Health Affairs Hospitals have been under in-house management since 1994 and that this transfer has been highly successful economically. By the end of 1996 it had reached its objective of running both its administration system and taking care of its own service maintenance had been able to save more than 50% of the costs which had been offered by the private companies Al-Abduljabbar (1997). Whether such a saving can be maintained is doubtful, but, nevertheless, it is impressive.

The in-house managed system, according to Al-Abduljabbar (1997), has, as one of its main objectives, to try to replace non-management personnel by qualified, skilled Saudis. Formerly, the National Guard Health Affairs used to depend on foreign workers to run the administration services and, in the beginning of 1996, the administration reviewed their whole objective. They started to control spending and began replacing expatriate staff with skilled, qualified Saudis. As a result, they cut 7% from the foreign manpower costs. The administration hopes to continue with the Saudisation plan in order to fill all positions with skilled Saudis. Though, from

accounts in much of the literature, it is noted that there is a shortage of skilled Saudis for these positions.

With the same budget from the Ministry of Finance, when the in-house management took over from the contractors at the King Fahad Hospital in Riyadh, considerable sums were saved which, subsequently, became available for other things, for example:

a) expansion of kidney units;

b) increased funds to provide more surgical beds;

c) implementing out-patient, one-day operations;

d) additional intensive care facilities for the elderly;

e) modernising and expanding the maternity and ante-natal unit;

f) modernising the X-ray department;

g) additions to the MRI unit; and

h) improving the accident and emergency facilities (Al-Oraij, 1998).

With the same financial resources as for contracted-out management from the Ministry of Finance, the King Khalid Hospital, Jeddah:

a) established a surgical unit for tendon and ligament injuries;

b) expanded the paediatric unit for dealing with tumours;

c) established an out-patient one-day surgery department;

d) increased the number of department clinics;

e) increased the number of beds and operating rooms (small); and

f) established a home-care department (ibid.).

With savings evident on this scale, it seems obvious to wonder why the contractors' costs were not more closely monitored, and why the contractors were allowed to overcharge the hospitals for their services.

There has been other research regarding potential cost saving in the health sector by changing over the management of the hospital from contracted-out to in-house: Ogail and Ammar (1995); Said (1997); Al-Oraij (1998); Al-Sugare (1998) and Althumali (1998). However, most of these studies deal with problems with contracting-out and *possible* savings rather than actual savings. Few figures are given to sustain their arguments.

When it comes to comparing the situation in Saudi Arabia with elsewhere as regards in-house management, problems arise in trying to find specific examples. None, so far as the researcher can discover, deal with hospital management. There are examples from the US of the changeover from contracted-out services to in-house managed services, for example by the Chicago City Council's refuse collection department (see below in this chapter). This resulted in considerable savings and they found it to be a more satisfactory system.

When the benefits, real or potential, are examined, apart from cost, which in-house management can provide, which cannot be provided, or are difficult to attain, when under contract management, there are a considerable number of studies, many by Middle Eastern scholars. These writers' views of the benefits will be examined under the following headings:

1. Possible saving of money.
2. Making the Saudi health services more efficient.
3. Increasing Saudisation.

2.5.1.1 Possible cost savings

When an organisation employs non-nationals through a contracting agency, then the costs are multiplied (Said, 1997) as the agency needs paying; the foreign worker needs a good salary (higher than s/he would obtain at home) as an incentive to move abroad; the worker expects airfares, accommodation, leisure facilities, school fees for children, and paid leave. None of these expenses would apply were a Saudi national employed in the post. Where it is necessary to bring in a non-national for a specific task then a government agency could be the employment agency.

The contract may cover everything. Supplies, such as computers, would be cheaper if bought by in-house management rather than by contractors. Contractors who win bids often employ low-paid workers and the result is low productivity, which again results in increases in cost to the contractee (ibid.).

Mufti (1996) points out that in-house hospital management, not subject to three-yearly bidding rounds, can think longer term and therefore could introduce savings more easily than under contract management, in particular for power and water. The more stable management environment would allow the introduction of better ways to improve the efficiency of the system and at the same time reduce costs, for instance in the case of bed use and staff deployment. The hospital would have more of a

vested interest in introducing better ways of utilising new technology, and exploring other medical alternatives to costly procedures (Al-Oraij, 1998). The monitoring of health care contractors, and the problems occurring every three years in the change-out period not only are time-consuming but very expensive. Al-Oraij (1998) and Said (1998) maintain that the stability engendered by having an in-house managed system would be cost effective.

2.5.1.2 Management efficiency

In order for a system to be deemed efficient then it must produce the required results in the best possible time, by attainable methods and be cost effective (Hannagan, 1995; Hickson and Pugh, 1995). Many proposals have been put forward for making hospital management more efficient by introducing a system of in-house management. Al-Abduljabbar (1997) claims that, since the changeover to in-house management, the administration system in the National Guard Hospital is considered the most efficient management systems for the military hospitals and its total health affair. Other writers, taking the cue from what happened in that hospital, go on to produce long lists of what they consider would make all hospitals more efficient. Those suggestions that relate to in-house management can be summarised as follows:

a) Loyalty of workers to the hospital is more likely where the workers are assured of continuous employment and are "belonging" to the organisation rather than temporarily employed by a contractor (Ogail and Ammar, 1995). This view was also held by Harvey-Jones, (1993), Hickson and Pugh, (1995) and Hannagan, (1995). This seems to be a very valuable point as under in-house

management the workers will be part of the organisation and so be familiar with its ethos, management and the rest of the staff on a day-to-day basis. They are aware who is responsible to whom and the role that they play in the organisation now and in the future. Where the management is of the same culture as the workers, communication is enhanced (Hickson and Pugh, 1995).

b) Flexibility is possible under in-house management (Ogail and Ammah, 1995; Mufti, 1996). This is very important when unforeseen emergencies arise and changes in procedures used to be introduced at short notice. Contractors only contract for a specific job and are not empowered to step outside their brief.

c) Continuity of employment creates a satisfactory atmosphere. Where workers are contracted for a short period only, much time can be wasted in the introductory period and a 'go slow' is possible as the contract draws to a close, especially if the possibility for renewal is not envisaged (Hannagan, 1995; Said, 1997; Oraij, 1998; and Pincock 1998). At first, the solution to this problem might appear to be to extend the contracts.

d) However, when one realises that the skilled contracted workers have been brought in to an alien country, in terms of climate and culture, that they may have relatives in their home countries, and possibly children which they wish to educate in their own country, then the attraction of short term contracts from the worker's point of view becomes more obvious. The contractors who, initially, are not certain whether circumstances will remain the same as the initial contract indicated, may not wish for longer period contracts.

When considering the question of what benefit the Saudis can hope to obtain from in-house management which they cannot obtain from contracted-out management, it is necessary to be aware that the situation in Saudi Arabia cannot be compared with Western Europe and North America, where the contractors' staff mostly involve local expertise. In Saudi Arabia, as Al-Sugare (1998) and others have pointed out, the urgent need to develop the country within a short period and to bring its institutions and service requirements in line with the developed countries, meant it had to bring in skilled experts from such countries. Local private firms lacked the expertise to establish and maintain high technological equipment. It was impossible to recruit and train Saudi workers rapidly. There was a shortage of possible workers and the fact that Saudis did not relish undertaking some tasks did not improve the situation. None of the many writers on Saudi development dispute this fact. However, relying on bringing in a large foreign workforce created problems in itself, in addition to the cost factor referred to above. It is these problems which impede the introduction of in-house management in the opinion of Al-Oraij (1998) which is, also, held by other specialists in the field of management, e.g. Hickson and Pugh (1995), Harvey Jones (1993 and 1995), Hannagan (1995), Said (1997), and Althumali (1998). The ultimate goal of in-house management is to achieve the complete Saudisation of the workforce (Al-Gubaisi, 1997:34). This complies with the aim of the Saudi government as stressed in its fifth Five Year Plan.

Hussain (1998:24) put forward what he believes could be possible if, instead of hospitals having contracted-out management, then had in-house management and a Saudi workforce. They would be able to:

a) Establish and develop national abilities;

b) Provide sustained employment for nationals, thus increasing their expertise;

c) Increase technical knowledge to reduce dependence on outsiders;

d) Save money, as it would be cheaper to employ nationals.

The attractions of in-house management appear unassailable. However, he did recognise possible obstacles: cash flow; getting spares on time; shortage of technical staff; inexperienced local staff; inability to limit budget ahead of time; and the present lack of technically highly-trained supervisors. He did suggest that these obstacles could be overcome by: management expertise; limit varieties of technical equipment so reducing the need to deal with different companies supplying similar goods; provide on-the-job training; provide incentives for technicians; and employ non-nationals only for highly technical services.

Other writers, such as Mufti (1996), considered that the way to achieve effective and efficient in-house management was to tighten-up procedures, define policies, provide detailed job descriptions, and introduce better ways of utilising new technology. Hussain (1998) believes that in-house management activities can be conducted more smoothly by eliminating the problems involved in the changeover of contractors (after their three-year contract period). In-house management would remove the duplication of management, necessary when managers are needed for both the contractors and government supervision, thus saving both time and money for the government. Overseeing the contractors' work can result in conflict between the supervisors and the contractors, again involving time-wasting procedures. In-house

management opens up recruitment for nationals and provides these people with much needed opportunities for developing management skills (ibid.).

Whilst many other writers, including Mufti (1996) and Al-Fawaz (1998), are of the same opinion, nevertheless Al-Faleh (1987) suggests that the situation may not be as straight forward as these writers suggest. He maintains that 'Arab culture has certain distinctive characteristics which dominate managerial thinking and behaviour' (pp. 20-21). This author is an Arab, working in an Arab culture. Together with the literature and his own research, all suggest the following observations about the distinctive nature of Arab management:

a) Within an organisation, status, position and seniority significantly outweigh ability and performance.
b) Organisations are centrally controlled with a low level of delegation.
c) There is little opposition and resistance from subordinates.
d) Nepotism is regarded as natural and acceptable. Arab managers view their organisations as family units and often assume a paternal role in them.
e) Punctuality and time constraints are of much less concern than in Western culture.

These factors may impede progress towards in-house management. Hickson and Pugh (1995) maintain that the situation in Saudi Arabia has not changed radically since Al-Faleh's opinion of the situation in 1987. The Saudis, in their opinion, still share the tendency to be centralised, even authoritarian (p.211). 'The abrupt arrival of Western forms of organisation, from Aramco onwards, pitched Saudi Arabians into trying to comprehend and work with Western management models, in a society

which aims to sustain traditional ways, as befits the cradle of Islam' (ibid., p.210). However, they also point out that not all Saudi managers do everything on Al-Faleh's list all the time.

An examination of the opinions expressed above by Al-Faleh and by Hickson and Pugh does suggest that in-house management is more likely to be effective if the majority of the staff is Saudi under a Saudi managing director, rather than a Saudi exercising control over a mixed-nationality staff.

In conclusion, it can be ascertained from the literature on both management systems that there are pros and cons for both systems. However, it seems that in-house management is favoured by Arab writers for the following reasons:

a) it can be seen as a way of opening up opportunities for Saudi careers and opportunities for advancement;
b) where contracted-out management is predominantly under the control of a non-national, the organisation can be viewed as alien dominated, that is: not ours;
c) where there are dissimilarities in language and culture the possibilities exist for misunderstanding and taking offence in everyday situations, which adds nothing to harmony in the organisation.

Some writers, including Bin-Said (1997) and Al-Driess (1998), have put forward suggestions for improving the contract situation and other aspects of management, for they recognise that even where the hospital is under in-house management it will be necessary to contract-out for some services and supplies. Bin-Said (1997) stresses

the importance of getting the private sector to work in harmony with the public sector for building projects, supplies and cleaning, as well as health care workers, and sees the need to get the private sector to help to improve the public sector.

In the transfer period from contracted-out management to in-house management there is a danger, Bin-Said sees, that in order to satisfy employment requirements Saudis who are poorly qualified may get jobs. Therefore, there is a need for employers to be trained in management fields so that 'they are aware of problems in all facets of the organisation and have well-tried ways of dealing with them' (Bin-Said, 1997:1).

2.6 Privatisation programme

Over recent decades privatisation of public sector goods and services has come to be recognised by many economic theorists and business managers, such as Elcock (1995), Al-Rashade (1996) and Muhanna (1998), as producing management efficiency. Many writers, such as Marstan (1988), Osborne and Gaebler (1992) and Azzam (1994), believe that for lower cost, the private sector can manage and operate the same level of provision of goods and services as provided by the public sector, and this will reduce the financial burden on annual budgets. Whereas others, such as Miller (1988), Heinbuch (1994) and Elcock (1995), question this assumption. Elcock goes so far as to state that it is a dangerous fallacy to believe that there is a generic method for management.

Jary and Jary (1991), have given the term 'privatisation' a meaning which is not intended to denote 'socialisation'. Hanke (1985:101) defines privatisation as denationalisation, and 'the transfer of public assets, infrastructure, and service functions to the private sector'. Privatisation also refers to those circumstances where control of an activity is passed from the public sector to the private sector. Privatisation is the use of a non-government organisation to produce some goods or service that government, as a policy matter, has decided should be better provided by private sector. Al-Rushaid (1996) and Prager (1997) shared the opinion that privatisation can be defined as any process which involves transferring activities wholly or partly (e.g. by short or long term contracts) from the public sector to the private sector.

Where government was formerly the sole supplier of everything for its own people, now privatisation programmes are opening up supply to the free market, offering, it is claimed, not only value for money, and an expansion of the national economy by attracting more of private investments, but opportunities to develop into the global economy (Hickson and Pugh, 1995).

Before this can be examined both generally, and specifically in the case of Saudi Arabia, the role of public administration should be examined in order to understand the reasons for privatising / contracting-out of services hitherto undertaken by the government on behalf of the people, and what has proved to be the advantages and disadvantages of changes of management.

Privatisation is a relatively new phenomenon. The term has many meanings: to different people, in different countries, and at different times. Different cultural circumstances have led to different interpretations (Hickson and Pugh, 1995; Al-Rashade, 1996). According to Pascal (1981) privatisation occurs when a government body turns over responsibility for the supply of a public service to private firms. Al-Rashade (1996) generalised that any activity aimed at changing the mix between private and public sectors can come under privatisation programmes. Henuming and Mansoor (1988) have described privatisation as an opportunity for international investors to improve the efficiencies of an enterprise, and reduce political pressure on it to perform to set policy. In their interpretation of privatisation, Crawford and Krahn (1998) stress that it involves transferring the production of goods and/or services wholly or partly from the public sector to the private sector, as they believe that private sector can provide public services cheaper and more efficiently than provided by public sector. Whereas Greenwood and Wilson (1993) saw privatisation as a threat to professional authority, and as selling off public-sector assets at less than their market value, so as to expand the private sector and, thus, reduce the number of civil servants. This would, they saw, inevitably increasing the price paid by consumer, as they would pay the real price instead of a government-subsidised price. Examples include contracting-out refuse collection by UK local authorities, inviting private investment in public projects such as in factory building or urban redevelopment, and British Gas, in 1986, contracting-out services.

In Britain in the 1980s and 1990s the government was committed to reducing the role of the state. Individuals were compelled to become more self-sufficient and public services were exposed, as far as possible, to market forces, chiefly through

privatisation and submission of public services to competitive tender in order to increase their efficiency (Theakston, 1995, and Elcock, 1996). From this flow two sets of issues:

a) effects related to an environment/threat and subsequently the process of privatisation, that is, the transfer from state ownership or management into private ownership or management, for instance, for the employees, the threat of redundancy, the opportunity of voluntary redundancy and early retirement, and an expectation of poorer terms and conditions of work; for investors, the opportunity to speculate.

b) effects related to an enterprise being owned or managed privately, for instance, being able to raise capital on the open market, and no longer being regulated centrally.

Privatisation is also defined in terms of the state selling all or large blocks of stock, in whole or in part, to the general public (Vuylsteke, 1988). When the government owns only a portion of the stock, a joint state/private ownership of the enterprise is created. The state can thereby remain involved in control of the enterprise. This allows the government to exercise some level of control over the enterprise, which means the private sector (investors, administrators or management) may not be able to exercise its full authority as they are limited by the government involvement. Al-Rashade (1996:29) noted that the privatisation process refers to the involvement of private sector, that is private enterprises / establishments, national or international, in providing the financial backing, the skilled staff or the internal processing, such as production, transportation, and delivering goods and services, instead of a state-owned enterprise. He observed three possible methods of privatisation:

a) devolving easy options to the private sector, such as design, investment, establishing, expansion of an existing sector,

b) transferring the ownership of state-owned enterprises to the private sector, wholly or partially, the latter involving stock sales to the extent of maintaining a controlling interest; and

c) contracting-out whole or letting publicly-owned assets to the private sector for full management and operation.

Sharbini (1997) clarifies that the privatisation process is only one of the more important, wider and more comprehensive process of transfer to "marketisation". Muhanna (1998), however, sees privatisation as an integrating policy that builds on marketisation, private sector initiatives and essential competitiveness for public growth and social justice. In other words, privatisation could be considered a global vision of how national economies can be made more efficient and effective.

According to Beesley and Littlechild (1983:13) the term 'privatised' means that companies have been given a greater incentive to produce goods and services in the quantity and variety according to consumer preference. Companies that succeed in satisfying consumer needs make profits and grow, whereas others that are less successful at this may fail. The resulting increase in unemployment is a social cost, as would be any increase in crime that would eventually be added to health cost. These would also, represent indirect additional government costs.

2.6.1 Methods of privatisation

Although private provision of local services on a small scale has existed in the UK for many years, its popularity as an alternative to direct public provision grew rapidly in the early 1980s. This growth is generally attributed to the wave of fiscal conservatism, which has characterised the rebellion against 'big government' in many industrialised nations of the West (Ascher, 1987). By 1982 the Conservatives elevated contracting out to a 'policy' status. The object was to introduce greater competition into industries, thereby improving efficiency and reducing the cost to the public. By 1985 about a dozen asset sales had been completed and some 400,000 jobs transferred to the private sector (ibid.). A number of methods of privatisation, identified by Pirie (1985), were employed, as shown in Table 2.3.

Table 2.3: Methods of privatisation

No.	Method	Example
1	Selling the whole	Amersham International
2	Selling complete parts of the whole	English Channel Ferry Services
3	Selling a proportion of the whole	British Petroleum
4	Selling to the workforce	National Freight Corporation
5	'Giving' to the public	British Telecom discounts
6	'Giving' to the workforce	Hoverspeed
7	Charging for the service	NHS prescription charges
8	Contracting-out	Local authority and NHS services
9	Diluting the public sector	Road funding
10	Buying out existing interest groups	Council house sales
11	Deregulation via voluntary associations	Aviation (CAA)
12	Encouraging alternative institutions	University of Buckingham
13	Making small scale trials	Freeports
14	Repealing monopolies	Bus and coach services
15	Encouraging exit from state provision	Social security (private pensions)
16	Vouchers	Transport tokens
17	Curbing state powers	Private searches
18	Divestment	British Gas
19	Applying liquidation	Hospitals
20	Withdrawal	Quango activity
21	Right to private substitution	The 'right to repair'

Source: Pirie (1985)

Table 2.3 shows the extent to which denationalisation varied in the UK. The UK government's programme to privatise public enterprise had two main elements: *denationalisation* - the sale of a state enterprise's assets or shares; and *liberalisation* - the relaxing or abolition of statutory monopoly powers (Heald & Steel, 1986). As far as the former is concerned, the extent of denationalisation varies. In some cases the entire assets of an enterprise or all of its shares were being sold. By 1985, this had happened to, among others, Radiochemical Centre (renamed Amersham International) and some of the National Enterprise Board's subsidiary companies, and steps were in place to extend this policy to British Gas's oil interests and some of the subsidiaries of British Rail and British Steel (ibid.).

In other cases the government converted public corporations into Companies Act companies and then sold a proportion of each company's shares, thereby creating a hybrid company. The idea was that these new companies would raise their capital from the capital market and then would be free from any form of control by government ministers, other than that applied to all companies.

This policy has been pursued for British Airways, the British Transport Docks Board and British Gas's monopoly of North Sea gas and its sale to industry and the disposal of gas showrooms to the private sector.

The most serious obstacles encountered by British public administration in implementing its proposals were the poor financial health of many of the enterprises involved, and opposition from both management and unions. The latter opposed privatisation in principle though the change of emphasis brought about by the

reformation of the Labour Party into New Labour in the 1990s and the subsequent winning of the 1997 General Election changed the attitudes of many former Labour supporters to one of embracing privatisation for 'the future of the industry' and the former were afraid of breaking up an erstwhile successful organisation, part of whose success depends upon the integrated nature of its operations.

Pirie's definitions are very broad. A more sophisticated approach, was put forward by Ascher (1987) breaks privatisation activity into four classes:

1. Denationalisation: selling off of nationalised industries to the private sector and the gradual withdrawal from comprehensive public provision in areas like education, health and the social services.
2. Substitution of customer fees for tax finance, an example of which can be found in the ever-increasing charges for NHS services, e.g. prescriptions for medicines.
3. Abolition or relaxation of the monopoly powers of nationalised industries, e.g. British Telecom and the telecommunication industry.
4. The contracting-out of public services to the private sector. Under contracting-out arrangements, public authorities continue to bear direct responsibility both for the provision arrangements and for the quality of service provided although the work is actually carried out by employees of private firms.

Unlike several other forms of privatisation, contracting-out does not signal an end to public sector control; state agencies continue to plan and finance the services involved. Although contracting-out first appeared in local authorities as a remedy for particular localised service problems, it was soon captured and made the subject of a

major national initiative designed to improve productivity and performance at local level in the health service (ibid.).

The question of the most appropriate means of service delivery has only recently become controversial (discussed below). In-house provision was accepted for many years as the most effective mode of delivery for a great many public services throughout the world. There are a number of reasons why these services grew up in the public sector as opposed to the private, the most obvious of which is that there were simply very few private companies able and willing to provide the sort of services that citizens had begun to demand. This was certainly the case in Saudi Arabia (Al-Munief, 1995).

However, many who accept the rationale behind direct provision of public services, nevertheless believe the rapid growth of the welfare state has led to diseconomies of scale and that specific services are no longer provided efficiently by the public sector. Not all alternatives to public service are market based. In many countries including, for example, Saudi Arabia (provision for pilgrims), Britain (lifeboat services) and Americas (some ambulance services, in particular in inner-cities), the voluntary services perform essential functions at no cost to the state, as they are supported by both gifts of money and/or equipment and voluntary helpers.

There are many public sector services in developed countries that central and local governments have turned over management, goods and services to private providers. It was noted that public sector job promotion is lower than the private sector as confirmed by Bennett & Johnson (1980:366), 'incentive structure in the public sector

hinders rather than enhances' efficiency. (Littlechild, 1981, Heald & Steel, 1982, Jones & Vogelsang, 1983), have noted that the private sector operates in a competitive environment; in order to survive, then must be efficient, in another word profit maximising, where the public sector has no such motivation. Privatisation, by emphasising profitability, is likely to mean the subordination of wider objectives. This may well be regarded as too expensive a price to pay by the government or consumers for public goods or services in many instances (Prager, 1997; Pincock, 1998).

Bannock *et.al.* (1978), Ascher, Mayor and Thompson (1986), and Pass, Lowes and Davis (1988), have used the term "privatisation" to refer to three interrelated strands:

a) denationalisation: the sale of State assets;

b) deregulation: the opening up of state activities to private sector competition;

c) tendering: the contracting-out of public provision to private sector.

They combined 'privatisation' and 'contracting-out' management and/or services as meaning the same. However, there is no distinction between the concept between privatisation and contracting-out, as contracting-out is one method of the many methods of privatisation. In its broadest sense, therefore, privatisation entails a simultaneous retrenchment of the government sector, and an expansion of the private sector in the provision of public goods or services (Prager, 1997). From the above discussion the following table summarises the advantages and disadvantages of privatisation:

Table 2.4: Advantages and disadvantages of privatisation

Advantages	Disadvantages
Management effectiveness	Deregulation
Private competitions	Government can no longer control prices
More money in fewer hands	Reduce budget by having fewer public sector employees
Free market	Government has fewer controls
Value for money	Government reduces social welfare
Expansion of the national economy	Private sector may rely on non-national expertise as of cheaper labour
Expansion of global economy	Selling off public-sector assets
Expansion international investors	Private sector continue to rely on subsidies
Reduces political pressure	Reduces civil servants unions as they may not get their benefits on time
Improve the efficiencies	Increase the price paid by the consumer
Reduce government subsidies	Consumer pay more than real price
Government reduces public services	Government reduces development in some areas

Source: adapted from the research data (1999)

The advantages and disadvantages resulting from the privatisation of a state-owned enterprise are summarised in Table 2.4.

In contracting-out process, Prager (1997) noticed that if contractors have to compete with one another in tendering for a contract, the winner will be the public organisation, which will be able to select the tender which is able to fulfil all its requirements with lower cost, where the government is the sole supplier, costs may be considerably higher and choice is eliminated. Therefore, contractors' competition can bring down the price of the contract for the public organisation management or other services. However, if the public sector reverts to contracting-out, the contractor working on a profit making basis usually cuts down the original workforce resulting in some workers being unemployed, another disadvantage is that there is no direct control of auxiliary staff and, as the public authorities privatise their organisations, social welfare is reduced (Peters 1996).

To achieve 'value for money'; strict control is placed on the acquisition of goods and services, so that the best service can be provided at the lowest cost to the public. However, when value for money is the main criterion, the government has less control over 'who does what' and whom the staff should follow: either the contractor (the private firm) or the state organisation. This uncertainty is a major disadvantage to the present workforce who could find they have to work in more closely-regulated conditions than formerly, thereby increasing stress; that they have to undertake on increased workload or, in the worst case scenario, that they lose job security, (Hannagan, 1995, Al-Oraij, 1998). So, 'value for money' may not apply in health care organisations' management rather than quality of management health services, Saati, (1998).

To remain a leading player in the present world economy, a country must continue to expand its national economy. For far too long many of the older industrial countries in Eastern Europe had relied on a limited number of primary products i.e. coal to sustain their economy. When they were forced by the market forces to expand their national economies, they did so slowly, developing their expertise in line with their industries' requirements. Where countries such as Saudi Arabia, have had expand their national economy at a rapid pace, they have been forced to rely on the assistance of non-national private companies and non-national individual experts, which has created cultural and economic problems for the host country.

The expansion of the global economy has been made possible by the proliferation of privately-owned international companies, staffed by experts, who are able and willing to develop the country's infrastructures, products and services which took them into the world market. This also have trained and educated nationals to carry over private enterprises. However, the disadvantage of the selling off national assets to private organisations, often foreign firms may get the benefit, as has happened and continues to happen in Europe, in particular in the UK, the private companies, usually foreign, have no allegiance to the country in which their business is located. However, the countries' economic advantage depends on the political stability, (Gylfason, 1999). This would make transfer of the business to another country or amalgamate with other private companies. Where either or both of these occur, the host country may suffers economically through reduction in the national economy, as workers receiving only social benefits.

Privatisation programmes provide for the expansion of international investment. International investors provide the money to develop resources and establish industries where national resources would prove inadequate. Successful investors can also withdraw their money resulting in the collapse of businesses. For example, the Ford motor company withdrew some of its investment from its branches in the UK in the 1990s, causing the closure of factories which supplied goods to the parent company, at Dagenham, Essex, UK, with consequent loss to local employment which had, and still has, repercussions throughout the adjacent areas. When former public organisations are privatised they are relieved of political pressure to perform in live with the government's 'programme'. Often this is not possible both for economic and logistic reasons. Many writers in the developed and newly developing countries governments are isolated from the actual workplace situation and so are unable to determine what is possible and what is not feasible to attempt (Hannagan, 1995). One disadvantage from the public sector employees' point of view is that it reduces the number of highly-paid civil servants who are no longer called on to 'manage' public organisations.

Many economists and others believe that privatisation improves the efficiency of an organisation by, due to the private company working for the profit, reducing wages wastage, but on the other hand the price paid for the goods or service has to be increased to improve profit margins' required by shareholders.

Government subsidies make it possible for industries to be established in places where private firms would not be attractive, but the cost to the exchequer is often too large to be sustained over a long period. The disadvantage of reducing subsidies is

that certain industries are no longer viable without the government subsidies. Therefore, privatisation programmes can reduce government subsidies over a longer period (Waznah 1996).

However, considering the advantages and disadvantages whether an industry / organisation should be privatised, it is prudent to examine the evidence obtained from earlier studies of privatisation, and to consider the advantages or disadvantages of privatising in general. Hannagan (1995) pointed out that the expertise of the administrators could vary considerably. Crawford and Krahn (1998:107) state 'Exercising effective management of an enterprise in which important roles assigned by a central organisation to contractors or other teaming partners has always posed special problems when compared with those situations that obtain when the central authority depends predominantly on its own workforce'. However, the only reasons it found that the private sector is more efficiency, firstly, because it operates with less bureaucracy and less red tape, and, secondly, it encourages competition (Hatry 1985). These arguments are based primarily on the assumptions of the ideal competitive free market. (Klees 1986:23) noted that 'the real world is far from the ideal of the competitive marketplace.' Hastings and Levie (1983) stated that social benefits are more important than economic efficiency. So rather than relinquishing all commercial control, and in order to control certain key sectors, some governments choose to retain a role in the management of formerly state-owned enterprises, so as to monitor the development of the national economy more effectively (Mills 1982). The state intends to hold some top positions to maintain to be the largest job provider for its people. However, the private sector takes its place to be the provider of public goods and services through privatisation programmes, as an alternative for providing

jobs and employment by the private sector (World Bank 1998). Therefore, variations of understanding privatisation policy are vast from one country to another (Al-Munief 1995). Some governments consider privatisation policy in the UK as a liberalisation and in the US as deregulation. This would allow decentralisation, and so increase flexibility and efficiency. However the privatisation process in the UK has yet to deliver the reward of performance improvements in all sectors, though reductions have been seen in energy and telephone costs.

Harik, Ilya and Sullivan (1992) stated that opponents to privatisation argue that there is a link between privatisation and foreign influence. The strongest charge against privatisation has been political in nature. Opponents of privatisation use the following arguments:

a) it is argued that, because, much that has been privatised is sponsored by foreign organisations, privatisation reflects the interest of advanced industrial states, which occupy a prominent place in world economy;

b) privatisation is considered to be a response to the political interests of the business classes, foreign and native, who put claims on the state and seek relief from obligations to the public;

c) business classes seek to dominate the state with a view to affect the distribution of national income in their own favour at the expense of the mass population.

A notable feature of the US privatisation programme was that it received strong support and public backing at the highest levels of the government, including presidents. Privatisation can be viewed as a pragmatic response to the low investment, inefficiency and deteriorating quality of the services of the public

enterprises. On the other hand, when the state has the capital, a desire to direct the course of economic development, and a policy of re-skilling the indigenous workforce, as in the case of Saudi Arabia, then a process of the state reducing the influence on the country of interests outside its borders makes good economic and political sense. This process, opposite in direction to the process of privatisation, could be termed nationalisation.

2.6.2 Political, social and economic benefits

During the nineteenth century, there were political movements throughout Europe that advocated state, public or shared ownership of the means of industrial production. In Britain, for instance, various political strands came together, based in part on the economic / political writings of Marx and Engels, in part on the popular / populist Chartist movement (seeking the political enfranchisement of the working class), and in part on a bourgeois liberalism, to form the politically left-of-centre Labour Party. In the Russian Empire, similar forces climaxed, first in 1917 with the October Revolution, and then in the 1920s with the development of a command economy under the Communist Party.

Both in Italy and Germany, during the 1920s, under nationalistic and increasing fascist administrations, nationalisation was used as an economic tool to complement private enterprise and to build the economy for self-sufficiency and national pride (Lewin, 1982).

After the Second World War, governments, for example in both the United Kingdom and France, believed that the state should operate the economy for the benefit of the nation. Thus the British government (under a Labour administration) nationalised parts of industry (such as the National Coal Board), transport (such as British Rail), and social provision (such as the National Health Service). In 1981-1982, there were 90 area health authorities have used contractors as cost saving, 'on the one hand, if the private contractor is better and cheaper, then costs are lowered; on the other hand, even if the service is still retained in-house, then the mere threat of competition can produce savings' (Pirie 1988:148).

This set the scene in the economically developed world for programmes of privatisation to be a rejection of state ownership. In the developing world, however, economic activity has, almost by definition, been weak. In this context, the state has acted in order to stimulate economic activity. Al-Munief (1995) and Sadik (1995) considered state ownership to be necessary wherever the private sector is undeveloped, lacks the necessary capital and is unable or unwilling to take a risk. However, with neither home-grown expertise nor the economic infrastructure, a state cannot act on its own. Contracting-out, such as in the case of Saudi Arabia, has been used as the way to create the economic infrastructure (Al-Munief 1995). In the case of Saudi Arabia, contracting out has necessarily involved the use of foreign expertise and foreign labour. The next step in the development of education, expertise and economic activities, therefore, has been an increasing emphasis on the Saudisation of both public and private organisations (Ministry of Planning 1996).

The economic intentions of the Saudi government have pulled public management of public organisations, such as hospitals, in two opposing directions. On the one hand, the Saudi government has wanted to stimulate the Saudi private sector, in order to reduce state involvement in the Saudi economy. (This pressure acts to prevent hospitals, for instance, coming under full state control). On the other hand, the desire to Saudise jobs and organisations has led to the development of in-house, rather than contracted out (largely to foreign-owned organisations) management (Al-Oraij 1998 and Pincock 1998).

Over the past fifty years, people born in any one of a range of economically developed countries (such as the USA, Britain and France), or increasingly in various fast developing countries, such as Saudi Arabia, have experienced almost perpetual interaction with facilities provided by the state. An increasingly strident political critique developed, objecting to the degree of dependency on the state for services, such as health, welfare, transport, communication and work. A child could be born in a state-funded hospital; receive education in a state-supported school and university; spend substantial chunks of the working day travelling on publicly-built and state-subsidised transport (e.g. Deutches Bahn); work for local or central government, or a state-owned industry (e.g. National Coal Board), or a state-subsidised industry (e.g. British Leyland); communicate through the government-controlled post office (e.g. G.P.O.) and the state telephone system (e.g. France Telecom); drink from public water supply; dispose of rubbish using the public refuse system; read books borrowed from a public lending library; picnic in local or national public parks, protected by public police, fire and health systems; be locked up in a state-run prison;

die, finally, in a public hospital, and may even be buried in a public cemetery (Marston 1988).

However, as a result of the processes of privatisation, in some of those same economically-developed countries and in Saudi Arabia as well, lifestyles have changed from being under the direction of state sector to being provided by private companies, sometimes including choice for the customer (e.g. the deregulation of electricity and gas supply in Britain), and sometimes not (e.g. the sale of British passenger rail service franchises). Each aspect provided by the state listed above, in Britain and the USA at least, is in all or some cases provided by private companies (ibid). Marston as well as other writers, fail to mention that a consumer benefit of privatisation is usually choice: the customer / consumer can choose from a range of suppliers.

The result of most, although not all, privatisations is that a number of companies step in to offer similar provision. Competition for customers arises between would-be suppliers, resulting variously in lower charges, better quality provision, or some other form of added value. For example, BUPA and the Nuffield Organisation in Britain compete with the National Health Service for customers by offering them customers speedier access to medical services, and more-hotel-like facilities, with the provision of soft furnishings, choice of menu, and unrestricted visitor access. These so-called luxuries in private health sector hospitals impact on public health sector hospitals, in that the public then view state-funded hospitals as inferior. In order to improve their image, state-sector hospitals attempt to provide better facilities and thus increase the cost of running public health sector hospitals.

For a government to take care of people's needs, it must offer people social and economic benefits. Manpower plays an important role in economics and in development of a country. Le Gand and Robinson (1984) noted that privatisation would increase inequality and decrease the sense of belonging, togetherness and unity in the society. When the government provides jobs, education, and development training, its employees are able to participate in developing their own country, creating a sense of unity and belonging. When discussing the impact of social culture on organisations around the globe, Hickson and Pugh (1995:9) pointed out that 'managing and organising are ultimately not separable from societies and their cultures'.

The objective of every government is to provide the services needed to satisfy and modernise its society. This is the broad focus of the public administration objective, whereas the main objective of private sector administration is to maximise its profits (Greenwood and Wilson, 1993). With profits, the private sector can satisfy its investors and can continue in business. Without profit, a business soon goes bankrupt (Teitez, 1968). When profits are uncertain, jobs become uncertain, and staff may consider jobs elsewhere rather than risk being made redundant. This interest in other jobs may affect their productivity, resulting in lower organisational efficiency. To remain competitive, therefore, a company must also maintain its profitability.

2.6.3 Theories about contracting-out

Contracting-out is a form of privatisation in which public agencies, such as central or local government, pays private contractors to supply a service or products. In

principle, a vast range of public sector services traditionally undertaken in-house, could be contracted-out (Hartley and Huby, 1998; Linowes *et al*, 1988), the terms and conditions being determined by the contract agreement (Ministry of Finance and National Economy 1993).

Contracting-out is a growing phenomenon. In the private sector it is sometimes referred to as "outsourcing", where a firm contracts another to supply goods or services. Contracting-out is common in the public sector, where public agencies contract with a variety of organisations to supply products (or services) that they cannot or costly to provide in-house. Ascher (1987) argued that most commonly a public agency will contract with a private firm or individual, although the public sector regularly contracts-out for both goods and/or services, where the focus of governments' recent interest is exclusively on the increased contracting out of the management. Services provision is labour intensive and therefore the more natural target for a government determined to reduce manpower levels and improve managerial efficiency.

When hiring, private contracts are usually through a process awarded which is known as competitive tendering. The most common form of competitive tendering involves private contractors competing against one another, either for new contracts or for these that have previously been in private hands and have now expired. Such operation cost public hospitals' staff time and money (6 months for preparation of documents), (Al-Oraij 1998).

In the UK increasing emphasis has been placed on the cost efficiency of service supply. Many recent competitive tendering exercises have involved services previously carried out by a direct labour force, and in most of these cases, the in-house workforce has been asked to compete against interested private sector bidders. Where the in-house workforce has offered the most cost-competitive alternative, it has generally retained the service and the contract price has become its budget. A weakness of competitive tendering is that, in favouring the lowest bid, an inexperienced contractor may be awarded the contract, which may result in a poor quality service.

Contracting-out within the government, for example, in the US, has a long-standing practice. Some trace it back to the reign of Elizabeth I (Kent, 1998:99). Often, contracting-out has resisted by those who view it as making unwarranted inroads into government employment (Crawford and Krahn 1998). By 1961, however, a majority of personnel being paid (either directly or indirectly) by the government were in fact being paid through contracts with organisations for whom they worked, (Heyman 1961). The trend continued. By 1980, 80% of the people involved in executing the department's service programmes were contractors (Sharkansky, 1980). Whereas Gone, (1993) also, considered that the services of the National Performance Reviews (issued by government agencies) provided additional impetus to the tendency to contracting-out as an important way of reducing government costs.

In studies of US refuse collection services, Greenwood (1993) shows that compared with the municipal service, the use of private contractors resulted in cost savings varying from 9% to over 40%. UK studies of refuse collection have shown that the

introduction of competitive bidding can shock a direct labour department into increased efficiency, leading to annual saving of some 20%. A survey by the Adam Smith Institute found American and British examples of where the use of private contractors had resulted in savings varying from 20% to 60%. Some limited interview evidence from specialist cleaning firms estimated the cost savings from outside contracting in the British NHS at 10-15% per annum.

Prager (1997) has carried out a study of contracting-out as a vehicle for privatisation. He stated that conventional wisdom that equates private sector with efficiency and the public sector with inefficiency is not entirely unfounded. He concluded that lower-cost private production does not necessarily mean a financial saving, as government protection is often more costly. However, contracting-out itself is costly and these costs must be considered prior to deciding in favour of external supplier, as well as the administrative and legal costs for specifying the contract terms.

Problems can and do arise when seeking to employ private contractors. Safeguards must be implemented. For example the past work record of private contractors must be researched. Jing Shiang (1995), when studying the contractual policies of Ohio Health Services, found that better service performance can be obtained from contractors if a system of positive incentives is instituted, in the form of financial awards, better working conditions and more freedom, by the board contracting them. High productivity and low costs were regarded the least important goal, by the contractor, (ibid).

Ascher (1987) stated that commonly an agency will contract-out with a private firm or individual, but it may also contract-out to voluntary or co-operative organisations, or to other public sector agencies. Although the public sector regularly contracts-out for both goods and services, the focus of governments' recent interest is exclusively on the increased contracting-out of the services. Service provision is labour intensive and therefore, the main aim target for a government determined to reduce manpower levels and improve managerial efficiency. For Ascher (1987) governmental enthusiasm for contracting-out is less to do with efficiency, in which quantity or quality may be a variable, and more about the lowest-cost method of supplying a given quantity and quality of service.

Contracting-out has a limited function, as some goods and services of the public organisation can be contracted-out to private organisations while still under the ultimate authority of the state (Prager, 1997). The government sets the overall framework in policy terms and specifies the objectives, whilst the private contractor is responsible for service delivery (ibid).

The impetus for contracting-out can also be intertwined with the need to achieve other institutional, social, political and legal purposes of organisations. Among those most frequently mentioned are for achieving and maintaining flexibility, quality performance, responsiveness, control and accountability. Flexibility is derived from an organisations' ability to respond more quickly to changes in its service demands hire contractors when demand suddenly increases (Rehfuss, 1989). Performance increases derive from the access to expertise and specialisation that contracting is said to offer, and by the contractor's profit motive. When competition is intense the

contractor will deliver their best performance to retain the contract (Donahue, 1989). It may, also, be through enhanced productivity, or improved quality of service, or through increased manageability from better co-ordinated service delivery. Responsiveness, control and accountability derive from the ease with which public organisation can terminate the contractor either through contract provisions, or through the availability of other contractors competition.

However, contracting-out has resulted in considerable controversy reflecting the views of the various groups likely to gain or lose from the policy (Hartley and Huby, 1998). The topic is dominated by emotion, myths, claims and counter-claims, many of which need to be confronted with evidence. Competitive tendering also offers a unique opportunity to compare the efficiency of the private and public sectors in a situation where both sectors are competing for a given level of service (ibid).

Contracting-out has resulted in considerable controversy. Many arguments, for and against, (Table 2.5) can be resolved by empirical testing. Some of the arguments obviously represent special pleading by those interest groups most likely to gain or lose from the policy. Private industry, which is likely to gain, will stress the benefits of 'free enterprise and competition'. Similarly, contracting-out will be opposed by those trade unions and professional associations whose members are most likely to lose from the policy. Participants in the debate need to state whether they are comparing 'ideal' states with actual institutions, or whether they are comparing two imperfect but real world organisational arrangements (Hartley and Huby, 1998). Moreover, any assessment of contracting-out and in-house provision raises questions about the aims of public policy. Much of the available evidence, especially on the

magnitude of cost savings, is limited, often based on US experience, is frequently flawed in that it fails to compare like with like, reflects political bias, and is usually based on casual empiricism (ibid.).

To examine the cases for and against contracting-out Hartley and Huby did a survey in 1984 and early 1985 by means of questionnaires, distributed to local authorities in England. Out of 410 distributed, 213 replies were received. Of those distributed to district health authorities (119 replies from 192 distributed) only 10 questionnaires provided data on actual contract experience, while a further 80 indicated their plans and offered views on the likely savings from competitive tendering; others declined on grounds that the issue was currently under discussion in the Health Authority.

The survey showed that contracts are not always awarded to the lowest bidder. Out of 75 local authority contracts, 18 were *not* awarded to the lowest bidder. Supporters and opponents of contracting-out will claim bias, favouritism, patronage and preferential treatment where contracts are not given to the lowest bidder (unfair competition). Where both private and public sector enterprises competed (57 cases), 14 contracts were not awarded to the lowest bidder and these were shared equally between in-house units and firms. However, the survey provided no explanation of why in-house units did not compete for all local authority contracts.

From this survey of firms, in 14 cases out of the total sample of 26 local authority and NHS contracts won by firms, the contractors paid lower wage rates than the in-house unit. Similarly, contractors often 'economise' on conditions of service especially superannuation, holiday pay, and sickness benefits (e.g. superannuation is

unlikely to be inflation-proof). Nonetheless, one industry representative claimed that even if contractors were required to use identical labour inputs, rates of pay, and conditions of service, private firms could still save 10 to 15 per cent compared with in-house units. All firms reported that contracts always contained penalty clauses. In 40 cases of firms that had won local authority contracts, there were nine instances where penalty clauses had been invoked for poor quality of work and seven cases where there were delays in carrying out the work. This changing over to or from contracting-out process may not be of benefit for the public health care sector, as time for patient is crucial.

2.6.4 Franchising method

Franchising involves conferring temporary monopoly rights of production and/or distributions of specified goods or services. Franchising can be viewed essentially as a mechanism for increasing market contestability. It does so by allowing for example, medical management firm to bid for the rights to supply personnel before they have committed resources to the enterprise. This means that franchising is a mechanism for providing the regulator with information about the competitiveness of potential suppliers.

Such information generation is entirely absent under traditional regulation and nationalisation and is a major advantage of the franchising method (Domberger, 1993). Another advantage of franchising over traditional forms of regulation is that it provides a sanction on poor performance, namely the threat of franchise termination, which may in some circumstances be a more credible sanction than the threat of

take-over faced by a regulated enterprise. However, as Domberger (ibid.) demonstrated, the implementation of franchise contracts is not without its difficulties, which may be considered under four headings:

a) The bidding process

To be effective franchising must be competitive. However, as Schmalensee (1979) demonstrated, this can be affected by collusive bidding. Other factors which are likely to reduce the number of bidders are start-up costs, which increase the penalty of exit upon franchise termination, and the information advantage acquired by the incumbent franchise during his contract tenure. The latter will increase the probability of the incumbent being re-awarded the contract and means that outsiders will not by bidding on equal terms. To avoid this happening, Domberger (ibid.) suggests, the characteristics of the contract must be clearly specified so that outside bidders have as much information about what is required as the incumbent.

b) Contract specification

Generating effective competition, which is what makes franchising superior to traditional forms of regulation, creates a problem of contract specification and selection criteria. Clearly franchising is likely to be most effective where the product or service to be supplied can be defined with relative precision (ibid).

Another issue concerns the problem of selection when the franchise involves supplying several jointly produced and well-defined outputs. This problem could, possibly, be overcome by the bids being based on a weighted average of product prices, where the weights are specified in advance to all contestants.

c) Contract duration

Contracts are typically awarded for a period of years. By shortening the length of the contract period it may be possible to make franchising more of a continuous process; though too short a contract period could create discontinuities in certain fields and would affect the employees' job stability, which then affect the efficiency and productivity of the staff, Al-Oraij, (1998). For example, franchisers may be wary of increasing production costs towards the end of the period of the franchise or reduces staff activities, in case their bid is not accepted.

d) Regulation and enforcement of contracts

Regulation of franchise contracts is, in principle, much simpler than conventional forms of regulation. On the output side what is required is no more than periodic (annual) checks of realised versus specified performance standards. As regards prices, the quasi-competitive price structure generated by the bidding process should be maintained during the franchise terms as the history of franchising is not short of cases of unrealistic bidding designed to get 'a foot in the door' in the knowledge that once the contract is secured, more favourable terms can then be negotiated and the base-period pricing structure adjusted towards monopoly levels. All the franchise has to do in order to achieve this is to persuade the authority that circumstances have changed significantly, namely that costs have risen (Domberger, ibid). A remedy would seem to enforce a contract that would make the initial price structure stick and

so discourage unrealistically low bids, because contestants would be aware that subsequent re-negotiation of prices is not possible.

This brief analysis of franchising indicates that a regulatory framework is essential in order to safeguard social welfare. Examples of activities in the UK public sector which have already been franchised include transport services, electricity distribution, cleaning of hospitals and schools, and refuse disposal. However, there is, as yet, no substantial empirical evidence on their performance level (ibid.). Therefore, franchising policy offers extensive opportunities for experimentation and a proper evaluation of actual experience.

2.6.5 Advantages and disadvantages of contracting-out

The commercial arguments for contracting-out vary, but generally include cost-effectiveness, lack of in-house expertise, the need to reduce overheads, greater administrative convenience and the need for increased flexibility to respond to changes in market conditions (Ascher 1987). The focus of most government's interest in the past two decades is on their perceived need to increase the contracting-out of public services. Knowing that service provision is labour-intensive and therefore the more natural target for a government determined to reduce manpower levels and improve performance efficiency (ibid).

Cost savings of contracting-out can only be determined when the government has properly calculated the cost of contracting-out. Contracted-out management must be added on to the price bids of contracts. Both government and private management

can be equally effective if both face the same market conditions and incentives. However, more expensive public production will not always justify contracting-out, for out-sourcing is not costless. The savings derived from employing outside supplies may not compensate for the costs of awarding, administering and monitoring contracts (Prager, 1997; Pincock, 1998). Table 2.5 identifies the general advantages and disadvantages of contracting-out.

Table 2.5: Advantages and Disadvantages of Contracting-out

Advantages	Disadvantages
Public sector 'in-house' monopolies are inefficient bureaucracies satisfying the wishes of producer groups rather than consumers.	Private contractors offer a poor quality and unreliable service.
Public sector inefficiency is reflected in restrictive labour practices and low productivity with its effects on rates, taxes, subsidies, and government expenditure.	Private contractors are liable to default and bankruptcy, and are less able to respond to emergencies.
There is an 'open-ended' financial commitment to public sector 'in-house' units.	In the NHS, private contractors put profits before people so placing patients at risk.
'In-house' units seek to provide 'Rolls-Royce' standards of service regardless of cost.	Awarding contracts to private firms leads to industrial relations problems and strikes.
Competition allows regular re-contracting by public procurement agents.	Contractors use low bids to 'buy into' attractive contracts and eliminate the 'in-house' capacity so that the public authority becomes dependent on a private monopoly.
Competition leads to new ideas, modern equipment, and changes in traditional methods of working.	Competitive tendering is not costless: there are costs to the public authority in specifying, monitoring, and enforcing contracts.
Successful firms in a competition are subject to the incentives and penalties of a fixed price contract.	Private contractors achieve cost savings by cutting jobs, reducing wages, and worsening working conditions.
Contractors can be penalised for poor quality, delays, and unreliability.	Result: Cost savings, if any, are short-lived and offset by reductions in the quality of services supplied.
Result: cost savings and 'better value for money'.	

Source: Hartley and Huby (1982), ed. by Redwood and Hatch, p. 289.

Table 2.6: Advantages and Disadvantages of Contracting-out in KSA.

Advantages	Disadvantages
Effective management	Lack of in-house expertise
More efficient	Did not witness the performance improvements
Less bureaucracy	Foreign influence
Less red tape	Political in nature
Encourages competition	Sponsored by foreign organisations
Free market	Social benefits are more important than economic efficiency
Share private sector, in order to control certain key sectors so as to monitor the development of the national economy more effectively	Inefficiency and deteriorating quality of the services of the public enterprises
The state will still hold some top positions to maintain to be the largest job provider	Response to the political interests of the business classes
Providing jobs and employment	Reflects the interest of advanced industrial states
Increase flexibility and efficiency	Prominent place in world economy
Foreign investment	Foreign and native, who put claims on the state and seek relief from obligations to the public
Private investment	Business classes seek to dominate the state with a view to affect the distribution of national income in their own favour
Profit making	At the expense of the mass population

Source: thesis discussion

The focus is on the experience of economically-developed countries. Table 2.6 were adapted by the researcher of this thesis from literature concerning the advantages and disadvantages of contracting-out in Saudi Arabia.

Most arguments in favour of contracting-out rest on economic-based notions that contracting-out is cheaper and better than its alternative that of direct, in-house, creation and performance of a service. For example, contracting-out can provide access to expertise than obligations to pay fringe benefits and other costs required to support directly employed staff. It provides an opportunity to pay for actual work received or through insurance health services. Most economic organisations react to changes in their economic environment in ways that optimise their position in the future economic cost effective. Thus, contracting-out has been mainly recommended and pursued with the hope of realising economic efficiency through cost reductions (Donahue, 1989). That means each situation may have its own culture, social, political and economic side effects, what may succeed in one may not be with the other, therefore a study case fore each situation would be very valuable to determine what benefit most can be applied (Al-Munief, 1995).

According to the Royal Institute of Public Administration in London (1984), opponents of contracting-out, outline a number of arguments against outside contracting:

a) In-house units and direct labour departments offer a better quality service more reliably.

b) A publicly-supplied service is better because it is not a subject to the profit motive.

c) Competitive tendering, contracting and re-contracting are costly.

d) Private industry lacks the capacity to provide a competitive response to a large-scale (public) demand.

e) Private industry is characterised by large firms, which are monopolistic and bureaucratic.

Another disadvantage needs to be added to this list: the lack of direct control by the general manager and senior staff over services which have been contracted out. An example of such a case in a Kent (UK) school is described by Cope (1995). In the 1980s Kent County Council contracted-out school cleaning in order to save money. The school cleaners were sacked and most were then re-employed by the contractors on lower pay and conditions. The reason why private contractors are often able to re-engage staff at a lower rate of pay is because unemployment and low economic growth created ... a situation where the supply of cleaners greatly exceeded the demand (ibid.). Therefore, the private contractors were able to employ cleaners on lower pay and offer significant savings to local authorities. By contracting-out school cleaning, Kent County Council moved away from being a delivery agency to a control agency. It no longer cleaned schools, but controlled private contractors that cleaned schools. When the private contractors took over they employed fewer women, thus creating unemployment, and where, formerly, the head teacher or another teacher in authority could ask a cleaner to undertake a specific job, now reference had to be made to the agency, as to whether such a task could be undertaken. This not only caused delay but sometimes could not be attempted as it was not in the initial contract (ibid). A similar situation has arisen in several hospitals in the UK, such as at Dryburn Hospital, Durham City (*Durham Advertiser, 12th April*

2000) where cleaners were, formerly, attached to specific wards and felt themselves to be part of the staff there are now contracted out, and they perform their hospital cleaning by going from ward to ward in a team effort and their instructions and overall control come from the agency situated in Middlesbrough, a town some 40 miles distant. These two examples show that contracting-out 'affects the vulnerable members of society (mainly women and unskilled)' (Cope, 1995:43) and that the loss of direct control by managers can have a detrimental affect on both the task required and the prestige of the workforce.

2.6.6 Privatisation in public health hospitals

Regarding the UK National Health Service, the quality of contracted-out work such as cleaning, laundry service (Newcastle District Health Authority have annually saved £60,000 and Cambridge DHA have saved £686,000 on domestic services), and sometimes, the nurses, doctors and associated staff in the hospitals and clinics, (Pirie, 1988). Whereas in the USA, for example, Jing Shiang (1995) noted that public agencies have contracted private firms to repair streets, collect the rubbish, clean buildings, and even manage and operate large hospitals. Jing Shiang (ibid) studied the contractual policies of Ohio county's Alcohol, Drug Addiction and Mental Health Services Boards and found that, overall, delivery of high quality of services is deemed to be the most important goal by the boards. High productivity and low costs were regarded the least important goal. Both boards and providers have a vested interest and so work together and co-operate successfully. In the public health organisation the greatest concern is for teamwork, not profit making.

In a questionnaire study of performance measurement in Irish health services, Millar (1999) showed that service deliverers and managers of those services do not regard themselves as accountable for the general medical services. From this it appears that the situation is similar to that found by Crozier (1996) in the UK where contractors and their employees see themselves as a discrete entity, rather than as part of a team working together to provide a health service for the patients.

The primary motivation for contracting out is to cut government costs by employing more economically efficient private sector. If so this may explain why have the move to allow a number of public hospitals to become under contracting-out management trusts is seen as an attempt to 'privatise' something that should be clearly be a state responsibility. Whilst among the private sector health care organisations, managerial efficiency may be improved by many of these reforms, the emphasis given to market forces and profitability introduces serious doubts about whether these health services will continue to be run for the public interest.

2.6.7 Privatisation in Saudi public hospitals

Developing countries have established state-owned enterprises in order to replace the weak private sector and to produce higher investment ratio with extra capital for their national economy (Shaikh, 1997). This means that the private sector in developing countries is not ready to invest or to operate strongly. Saudi Arabia not only provides finance to private sector healthcare clinics and hospitals, but also privatising management, that is by granting the private sector more opportunities to manage and operate public sector health projects. Although the Saudi economy is based on the

free market principle, the public sector is still seen as the generator of economic activities, as most of largest State Owned Enterprises, controlled or directed by an appointed chairperson (Al-Munief, 1995; Waznah, 1996), that is Aramco, Sabic and General Electric Ltd. Taking the practical steps to meet the growing demand for basic infrastructures, various government agencies such as Saudi Credit Bank, broadening its activities not only to finance local private small and large enterprises, but also, signing more foreign investment protection guarantees and agreements with the industrial countries, (Ministry of Planning, 1995) .

Saudi Arabia's Fourth, Fifth and the Sixth Development Plans (1985-2000) aimed to expand the privatisation programme in order to generate greater development in the economy. In particular, some services of the Ministry of Health hospitals, education, and some other public agencies were privatised in order to help expand the private sector role in management and services. The privatisation of the health care sector, it was stressed, must provide 'easily accessible free health care not only to the Saudi citizen' but also to all citizen' (ibid).

In the economically developed West, contracting-out has been used by governments in order to supply more cheaply management and services of comparable quality to in-house provision. In Saudi Arabia the case is different (Al-Munief, 1995, Al-Rushaid, 1996). Al-Amri (1995) noted that the impetus for Saudi public hospitals to contract-out to the private sector and so having to bring in foreign skilled workers was, due to the fact that there were very few Saudis with the necessary technical skills, not only for industry but also to serve the needs of the health sector. As the

country was developing rapidly, there is a need for skilled workers to develop and to train nationals (Viola, 1986).

In the 1950s when the oil wealth began to increase money was invested in training nationals. However when many technical and non-technical jobs became available in different geographical locations and Saudi refused to take them up, because of their desire to be in the vicinity of their families (Al Nughimshi, 1997). Saudi oil wealth forced the pace of change, so that modern forms of organisation were created almost before they could be well managed by citizens, and expatriate managers had to be brought in (Hickson and Pugh, 1995:195). Arab managers view their organisations as family units and often assume a paternal role in them (ibid).

Saudi Arabia has aimed to increase private investment in the national healthcare and the first Ministry of Health hospital was run by private sector in 1979, (Saati, 1998). Since then private sector participation increase to manage and supply services by contracts to 176 public hospital in year 1998 (ibid). Therefore, private health care sector offered investment opportunities train and develop professionals in technical and non-technical fields for health facilities. However, Saudi government supply the growth of the private sector of all medical and non-medical businesses, with land, and free interest-loans.

2.6.8 Types of private contracts used in the Saudi public health sector

The cost of the health service is fully met by the Saudi government and the fast expansion of the number of Ministry of Health hospitals doubled almost three times

between 1980 and 1988. This has made it very difficult for the Ministry of Health to fill all vacant positions and operate efficiently. This resulted in a great shortage of health manpower, which made international recruiting a necessity, and management services had to be purchased from private management firms (Al-Harbi, 1990). By the end of 1989 there were about 30 Ministry of Health hospitals throughout Saudi Arabia, which were under contracted-out management firms (Table 2.3).

Table 2.7 shows that out of the 29 hospitals listed, only three are fully management contracted: King Fahad Hospital, Al Baha; Riyadh Dental Centre and the King Khalid Eye Hospital. This means that the contractor has all responsibilities of recruiting, operation and management of that hospital, while the purchaser, which is the MOH, will act as a supervisory agent under assigned terms and conditions which limits both parties acts. The principal reasons for these hospitals being fully privatised are that they offer services, which are highly specialised, have very expensive highly technological equipment operated by specialists (international and native) of international acclaim. The resources of these hospitals are beyond what is usually required by the other hospitals in Saudi Arabia. American contractors, who recruit worldwide management to run public hospitals, the remaining hospitals listed in Table 2.7 are only partially privatised. This means that the contractor has only some managerial responsibility for developing policy, procedures and recruiting for specific positions as specified in the contract, while the MOH provides most of the manpower services for purchasing and the delivery of hospital supplies, maintenance, transportation and housing for all staff (including contractors' staff).

Contracting-out is common in Saudi Arabia, and is characterised by deficiencies in certain technical specialities. The transfer of technology is usually accompanied by employment contracts to expatriate managerial personnel, at least until a core of local professionals can be trained to replace them, for example, in Saudi Arabia's public hospitals (Al-Harbi, 1990). However, in the case of Saudi Arabia the introduction of a foreign workforce produced problems for the government, when it sought to Saudise its workforce, as stated in all its Five Year Development Plans, but recently more focused on by the Saudisation programme announced in Fourth, Fifth and Sixth Development Plans (1985-2000).

Bin-Said (1997) noted that some hospitals, which formerly had contracted out management services but now have in-house management services, are proving more successful in terms of economy and more efficient in terms of streamlining staff and employing more Saudi nationals for the fast growing hospitals.

Table 2.7: Types of Private Contracts used in the Saudi Public Health sector

No	Hospital	Contractor	Contract type
1	King Fahad Specialist Hospital, Qassim	Al Mutbbakani	Partial
2	Assir Central hospital	Washington Health Care	Partial
3	Farasan Hospital	Whittaker	Partial
4	Gurayyat General Hospital	Zahran Medical Services	Partial
5	Majmah General Hospital	Zahran Medical Services	Partial
6	Hafer Al Batin	Zahran Medical Services	Partial
7	Prince Salman Hospital, Riyadh	Saudi Charter Medical	Partial
8	Hera General Hospital, Makkah	Saudi Charter Medical	Partial
9	Hera General Hospital	Saudi Charter Medical	Partial
10	Ohud General Hospital	Saudi Charter Medical	Partial
11	King Fahad Hospital, Madinah	Saudi Charter Medical	Partial
12	King Fahad Hospital, Gizan	Whittaker	Partial
13	King Fahad Hospital, Al Baha	American Medical International	Full
14	Afif General Hospital	Al Madar (Orbit Summit)	Partial
15	Al-Aflaj General Hospital	Al Madar (Orbit Summit)	Partial
16	Al Mednib General Hospital	Al Madar (Orbit Summit)	Partial
17	Al Bukairiah General Hospital	Al Madar (Orbit Summit)	Partial
18	Al-Ola General Hospital	Al Madar (Orbit Summit)	Partial
19	King Khalid Hospital, Al kharj	Almutabbakani	Partial
20	Maternity Hospital, Taif	Almutabbakani	Partial
21	Namass Hospital	Whittaker	Partial
22	Bal. Asmar Hospital	Whittaker	Partial

23	Sarat Abeedah Hospital	Whittaker	Partial
24	Al Majardah Hospital	Whittaker	Partial
25	Riyadh Dental Centre	Med& Scient Eqpt-Hse	Full
26	Rabigh General Hospital	Inter Dental Opment Group	Partial
27	Adum General Hospital	Inter Dental Opment Group	Partial
28	Qunfudah General Hospital	Inter Dental Opment Group	Partial
29	King Khalid Eye Hospital	American Medical International	Full

Source ;Al-Harbi, (1990:18)

2.7 Who should run public hospitals: medical practitioners or qualified managers?

Apart from the issue of whether health care services in Saudi Arabia should be provided in-house or contracted-out, other issues also face public hospitals in Saudi Arabia. An important issue to is the management leadership, whether a hospital should be run by a medical practitioner or by a professional manager. Whilst a medical practitioner is likely to understand medical matters, a professional manager has managerial expertise, and understands the functions of management. An aspect of this issue is how to encourage the medical staff to accept the authority of a professional manager, and to recognise that s/he is qualified to manage the hospital. In the UK, as a result of a transition during the 1980s, when hospital management transferred from medical staff to professional managers, there is now a specialist branch of management that focuses on working in the medical environment.

A problem facing public hospitals in Saudi Arabia is that business management, although given an increasingly high profile in economically-developed countries,

does not attract high calibre Saudi nationals to train for such a role. This may be due, in part to the low publicly-perceived status of the title: director/chief administrator. Even the medical profession is unaware of the amount of study and training required in order to qualify as business manager.

A further issue is how the Saudisation programme is to be applied when selecting a manager. Posts undertaken by non-nationals have now to be transferred to nationals. Therefore, Saudi nationals willing and able to fill these posts must be found.

A large modern hospital comprises a conglomeration of activities, facilities and staff engaged in activities, medical and non-medical. Non-medical staff are involved with activities ranging from building maintenance, gardening and laundry services, to the more sophisticated occupations of computer specialists, technicians, accountants and engineers. It would be unreasonable to expect anyone to have an intimate knowledge of these activities, but it is a manager's role to see and manage them all. It seems bizarre to expect a medical practitioner to grasp this overview and still have time to perform medical duties. A medical specialist is most effective and efficient when giving his time to patients and to medical research, rather than spending time on administration. Saati (1995) commented from an interviewees survey regarding this issue with some Medical practitioners chief executives of public hospitals in Saudi Arabia.. Where a medical practitioner is running a hospital, he/she must be highly qualified in management, or else he would not have been appointed to the managerial role. Some have mentioned that, it is possible for a hospital manager to be both a qualified medic and a qualified business manager. But whereas, discussed below, this dual role presents problems.

(Al-Amri, 1995) has argued that there are Saudis who have trained and are being trained in-house for hospital management to the extent that they have been awarded degrees in Business Management by internationally recognised universities. Why have not they been given the respect they deserve? , and for those who have qualified are they satisfied with their status and if not, why not? These questions will be examined in the light of available literature and attempts will be made to answer them.

Marston (1988) was adamant that there was a need for professionals not physicians to manage hospitals: 'One of the greatest weaknesses of the health system in all countries of the world is that of managers. Managers must be businessmen' (ibid, p. 22).

Hospitals are businesses and, therefore, have to meet the requirements of all businesses. They need to have plans for future developments, training schemes for the workers, opportunities for staff advancement, and to know their budget which limits expenditure and prevents waste and to be an efficient system of management (Hannagan, 1995; Crawford and Krahn, 1998).

When Saati (1998) was studying hospital management in Saudi Arabia he identified several disadvantages in having a physician as a hospital manager, even when they were qualified in business administration. One was the loss of his expertise as a medical practitioner. Even when the person only performs surgery part-time it still means that precious time is lost from his principal occupation, that of hospital

manager. Where the medical practitioner had little managerial experience outside the medical profession, there was a tendency to concentrate on and fulfil medical requirements rather than those of other departments of the hospital. With staff problems such a person is more in tune with his medical staff rather than staff from other departments, where he had no intimate acquaintance with their day to day problems. In medical matters, as in other sciences, there is usually a right or wrong way of doing things, that is, decision making is fairly straightforward. However, the difficulty that managers have to face, in a complex organisations, is that there is never a simple solution to any managerial problem (Harvey Jones, 1995).

Saati (ibid.) showed that there were certain advantages to a medical practitioner undertaking the role of hospital manager, for example, knowing what the patient needs, more than would a non-medic, getting co-operation more readily from other physicians, and having knowledge of suitable medical equipment (ibid.). A medical practitioner who has specialised enough to hold a senior position among the medical staff is unlikely to have expertise in medical fields other than his own (Heinbuch, 1994). This also applies to other paramedical departments, such as X-ray, physiotherapy and occupational therapy (Al-Bishi, 1991; Al-Amri, 1995).

The argument for having a medical practitioner as a hospital manager can be sustained in exceptional circumstances, such as in a small, non-specialised establishment, or if the person holding the post relinquishes his former role. Therefore, for hospital management, there is a need for professionals not physicians to manage a hospital (Marston 1988:2).

Before a supply of business managers is available to run hospitals, it is necessary to persuade suitable candidates to enter the profession. This is not difficult in economically-developed countries, such as the US, where business management has a high profile and the number of prospective students hoping to enter the most prestigious universities, such as Harvard and Princeton, to study the subject is in excess of places available (Hannagan, 1995). However, in Saudi Arabia the situation is different. Even where finance is available for people to study business management in the West, there is a marked reluctance on the part of many Saudis to see business management as a worthwhile career.

There are three possible reasons why hospital management is not seen as an attractive career for Saudis:

1. hospital management is considered by many people to be the domain of physicians;
2. hospital management is stressful, for hospital managers have to confront and resolve a number of difficult problems including the widespread practice of nepotism and related forms of family-centred favouritism (Al-Awaji 1971; and
3. the satisfaction rate of those already in the job is widely accepted as being low (Al-Amri 1995).

It seems clear from studies of business management literature that the profession requires a number of skills which are not appreciated or envisaged by possible recruits. As Hannagan (1995:20) states, the role of the manager has never been more rewarding or challenging and it has never been more important to understand this role. The manager's role is to organize and control people so that there is a productive outcome (ibid.). Therefore, the trained hospital manager is as much a

professional as the physician. Both roles in the healthcare situation are mutually dependent and have to be exercised for the benefit not only of the patients but also for society as a whole. However, Hannagan (ibid:203) reported the view expressed by Saudi hospital managers, that 'physicians are the voice normally heard for medical and non-medical matters'.

When conducting his study of bureaucracy in Saudi's private sector Al-Gubasi (1997) found that Saudis had problems accepting responsibility, due to what he termed the 'fear of conflict' (p.34). He found that they tended to shy away from innovation, and were unwilling to take responsibility even for minor decisions and had a fear of altering the status quo (ibid.). Madi (1975) had found a similar situation in his Saudi Arabian study and put this down to 'lack of training, poor selection of candidates, lack of encouragement, and a serious gap in mutual understanding between the superiors and their subordinates'. If this is a true representation of the situation, then it goes some way to explain the Saudis' reluctance to aim for senior management positions.

Satisfaction and dissatisfaction are difficult to measure, as discussed in detail below in Chapter 5, which considers qualitative fieldwork data. Dissatisfaction experienced by Saudis in positions of authority when conveyed to subordinates, or the public at large, could create the impression that such posts are unattractive and are to be avoided. Al-Amri (1995:32) quoted two expressions of such dissatisfaction:

a) Poor recognition for my speciality as a trained health administrator does not encourage me to stay where I am not recognized'.

b) Poor recognition of my speciality of training in health administration from my employer does not give me hope for promotion.

In spite of the lack of appreciation shown or felt by trained health administrators, proper utilization of trained health professionals is considered a basic element in developing Saudi health care services and reducing dependence on foreign professionals in the five-year development plans (Al-Dakhail, 1988; Al-Amri, 1995; Al-Gubaisi, 1997; Al-Bishi, 1999).

2.8 Summary

This chapter has examined public administration, hospital management and the pros and cons of private/public sector management, in general, and specifically in Saudi Arabia. The chapter has described how the public administration in any country responsible for providing the resources necessary for maintaining its population and determining how their services should be administered efficiently. This creates many problems for governments as the lifestyles of their people are becoming more sophisticated and, consequently, they expect their needs to be met speedily and efficiently, regardless of the resources available. In their turn their governments through their public administration, and public management have to attempt to satisfy public expectations. In order to do this, many developed countries have turned to the private sector for two reasons:

a) to reduce the public administration's role and budget; and

b) to provide more efficient and greater choice of services; in particular, for the health requirements of the general public.

The situation in Saudi Arabia was found to be in contrast with that of many developed countries, in particular the economically-developed West, as Saudi Arabia had the finance available, but not the resources in terms of manpower and expertise to carry out the necessary development. Therefore, Saudi Arabia had to import skilled and unskilled manpower, and also expert firms (with their own staff) to set up and carry out the necessary developments. This produced problems, which were examined fully in this chapter. One was cultural clash. However, expatriates required facilities beyond what was demanded by nationals, and as managerial posts were held by expatriates, so nationals failed to be promoted even though the standard of education in Saudi Arabia had risen considerably in the last two decades.

The government was faced with the need to promote its own efficient, effective and economic management, in particular, for its health services and that they would require an ever-expanding budget, which may not always be available in the future.
A government has two ways to manage public resources efficiently and economically: to privatise fully or partially, and to improve in-house management. Privatisation in other countries was examined, along with the case for and against doing so, based on findings from other countries, which have been discussed in relation to the literature. From these accounts it could be deduced that privatisation does not always meet with success. In fact, it appears, after trying out privatisation of some organisations have begun to see the value of reverting to an in-house

management system. In the light of these findings, the situation in Saudi Arabia was examined.

The reasons for the privatisation of public hospital management in-house versus contracted management were examined. The results gave rise to producing a case for more efficient and effective management of public hospitals. This led to seeking the answer to the question of who should run the hospitals. It was clear that in order for modern hospitals, equipped with high technology, to be run at maximum efficiency, then they required managers trained in modern internationally recognised techniques. Hitherto, the tendency had been to use a medical practitioner as a hospital administrator. Whilst this had been satisfactory in some cases, it was, as it was argued, both a waste of medical expertise, which was obviously needed elsewhere in the hospital, and that a doctor could not be expected to have undertaken the necessary management training.

In the case of supplanting expatriate staff with nationals, this was seen to be complex problem. There was no question that there were educated Saudi nationals, such as doctors, paramedics and nurses, who could be employed in the hospitals, though they are in short supply at present. In Saudi Arabia, the higher posts, as in many countries were and are occupied, of necessity, by expatriates: countries can rarely supply experts in every medical field. The need to have management training schemes for Saudi nationals was advocated. However, it was discussed, problems could arise with the lower ranks of employees, as the literature pointed out that many Saudis were reluctant to undertake menial jobs, so dependence on ex-patriots for years to come was envisaged. This could present a difficult problem for prospective Saudi

management and for the government's Saudisation programme. As expatriate managers, working under contract, usually have a large expatriate workforce under their management, recruiting appropriate Saudi staff was envisaged to be a possible problem.

The chapter has emphasised that one type of management system, in-house or contracted-out, which works in one country may not necessarily work in another. There are vast differences between, for example, the economically-developed West and economically-developing Saudi Arabia in terms of culture and economic activity. The purpose of privatisation schemes in these two economically-different environments is not similar.

As culture is not static, it is necessary to examine Saudi Arabia's culture, social history, economic development and its public administration system in detail, in order to evaluate contracted-out versus in-house management, in general, and in the health services in particular. This is the focus of Chapters Three and Four.

Chapter Three

Historical background of Saudi Arabia

3.0 Introduction

Analysis of the administration of a country involves not only examination of the state machinery, but the location of the state in its full geographical context. For example, Saudi Arabia, with its relatively small indigenous population, has historically had neither the home-grown expertise to set up and administer the huge commercial and social infra-structure typical of an economically-developed country, nor the raw manpower to carry out much of the labour. These demographic short-comings impact significantly on the public administration of Saudi Arabia. Further, it is only as a result of its vast oil resources that Saudi Arabia has been able to implement the growth of its public administration. The limited life of the oil resources have pressured the Saudi government, through a series of Five Year Development Plans, into economic diversification, involving the development of a range of industries. In this chapter, therefore, the terrain, climate, resources, industry and demography of Saudi Arabia are described in detail. The Saudi government's series of Five Year Development Plans are examined, alongside public administration and its development; economic policy and its development; privatisation policy; education, social development and the development of the health care services.

3.1 Relief

The Kingdom of Saudi Arabia occupies four-fifths of the Arabian Peninsula (see Figure 3.1) and has an area of 2,240,000 km^2. It is bordered on the north by Jordan, Iraq and Kuwait; on the south by Oman and Yemen; on the east by the Arabian Gulf,

Bahrain, Qatar and the United Arab Emirates; and on the west coast by the Red Sea. Vast distances separate many of the major cities, requiring a substantial transport and communications infrastructure. Being located in a geopolitically-volatile region, and particularly with the oil resources located towards Iraq and Kuwait, places an emphasis on diplomatic and military security.

The main highlands rise up to 1,800m above sea level in southwestern parts, and extend with variable heights to reach a peak in the northwest of the country, (see Figure 3.2). Due to Saudi Arabian's size and difficult terrain, logistical problems are created for the public services, such as health care specially as the population is unevenly distributed throughout the country: coastal regions being more densely populated, and the central desert regions (e.g. Rub al-Khali) being virtually uninhabited.

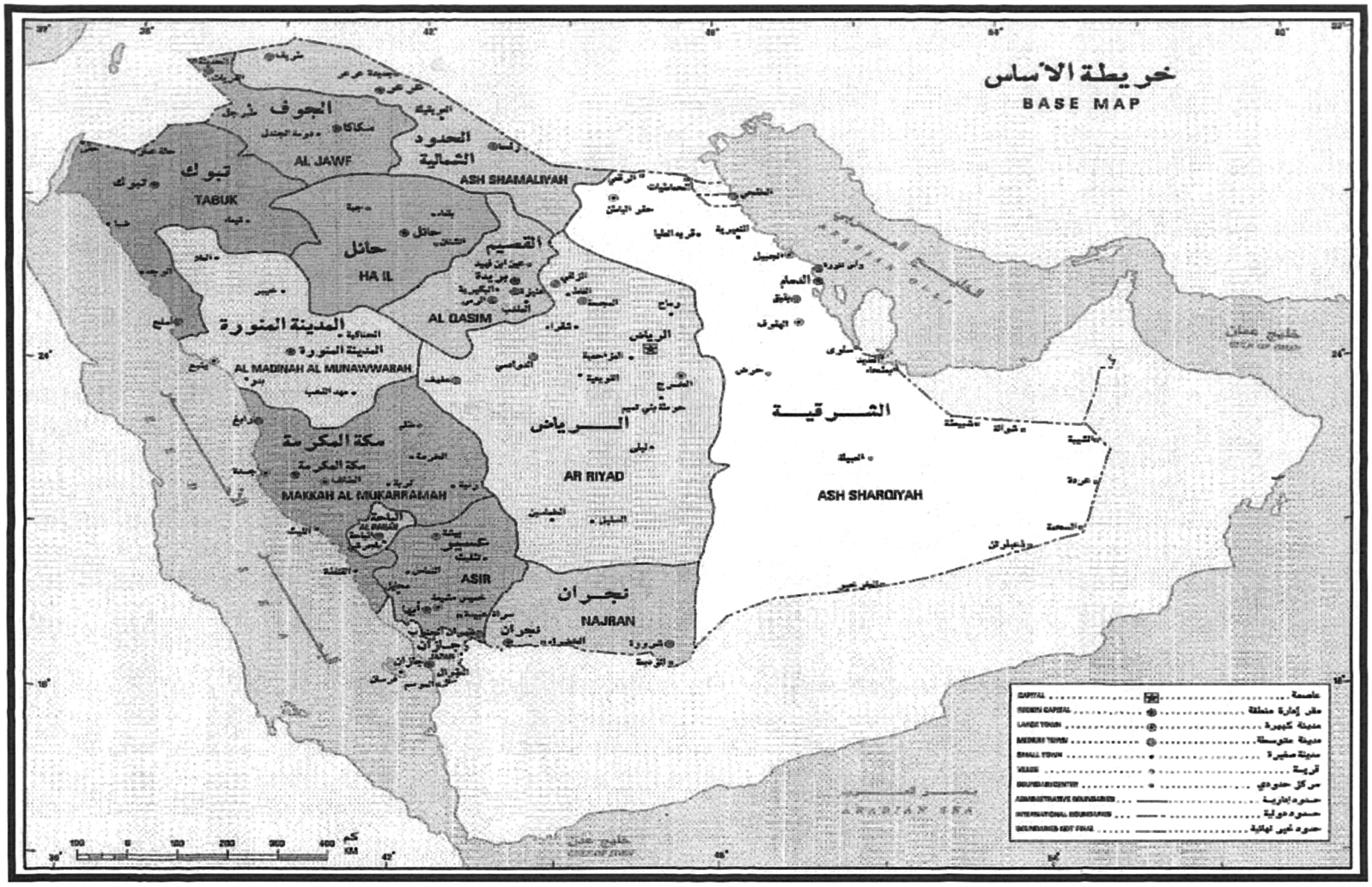


Figure 3.1 Saudi Arabia Administrative area

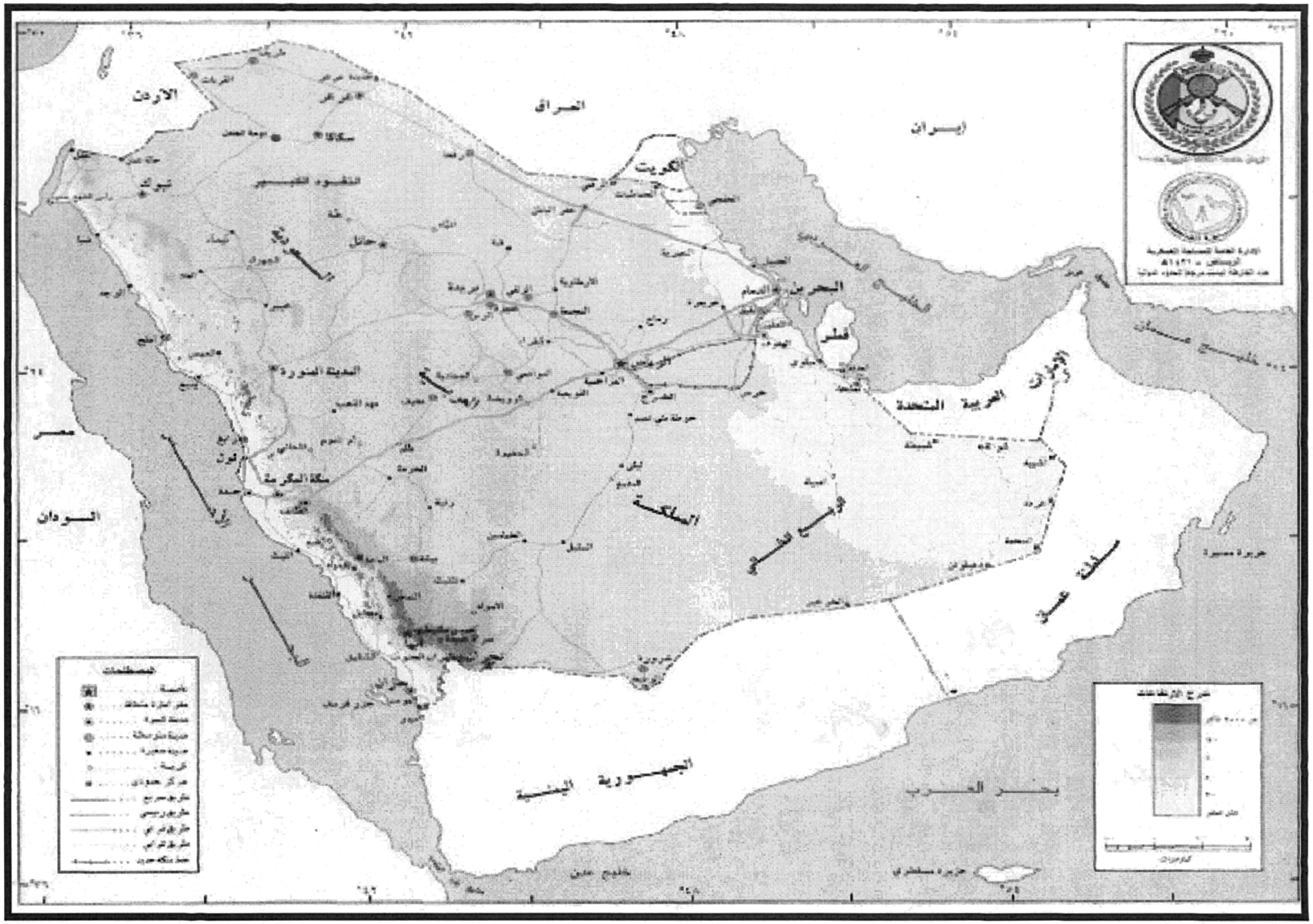


Figure 3.2 Saudi Arabia Physical Map

3.2 Climate

The climate of Saudi Arabia displays extreme ranges of temperature, varying from one region to another. The nation-wide average temperature is 18°C, with local averages varying considerably. In the summer temperatures in the middle, western and eastern regions vary from 30°C to 45°C. In the winter they can vary from 7°C to 33°C. Those regions located in the north and south-west enjoy milder weather for most of the year, dipping down to –3°C. The vast centre of the country experiences the typical desert climate of hot days and cold nights. The extremely high temperatures increase the number of hospitals visits and admissions. Demands are also made on buildings, such as hospitals (requiring both cooling and heating), and also on the operation of sensitive medical equipment, requiring air conditioning. Such equipment is also affected by the high humidity levels experienced in many of the coastal cities, for example Dammam on the Gulf coast, and Makkah and Jeddah on (close to) the Red Sea in the east. In Makkah region, sun stroke cases during Haij seasons total of patients was 905 in 1994, 152 in 1995 and 226 in 1996. However, heat exhaustion total of patients was 9675 in 1994, 5063 patients in 1995 and 3,093 in 1996 (Ministry of Health Annual Report, 1996). Death caused by sunstroke in Makkah region totalled 21 in 1995 (Ministry of Health Annual Report, 1995). Variation of the climate every year cause the relatively changes in patients total numbers, even though artificial rainfall is sprayed in the pilgrimage areas during the Hajj, and many hundreds of trees have been planted in some sacred places to help cool the climate.

3.3 Water

Scarcity of water can be life-threatening. Saudi Arabia, with its extensive deserts, is a dry country, with little precipitation. Apart from Jizan to the south west, there are no permanent rivers.

Water is used for three purposes:

1. domestic consumption (for drinking and for hygiene);

2. agriculture (irrigation);

3. industry (many industrial processes require copious amounts of clean water).

In order to meet the growing needs of its population for sustenance and hygiene, water resources have to be exploited. The near absence of rainfall in most regions means that significant amounts of public money have to be spent in producing potable water through desalination of seawater from the Red Sea, and pumping from groundwater and from deep fossil deposits. This has implications for public hygiene. According to 1994 estimates, surface water, and shallow ground water, together supply only 13.8% of the water needs of the Kingdom (Ministry of Planning, 1995). Availability of clean water reduces both the number of health patients and health care costs, allowing the provision of better health care services and better health care management.

From the beginning of the development of the country, the government undertook the expansion of its water desalination capacity. There are 29 water desalination plants on the Red Sea and the Arabian Gulf. These plants have a daily rated capacity of about 600 million cubic metres of drinking water. Some of the plants are also used to produce electricity. The largest single plant is located in Jubail and has a capacity of

240 million US gallons per day. There are plants at Jeddah, Alhkobar, Makkah and Taif with daily rated capacities of 101.8, 57.5 and 48 million gallons respectively. Plants at Madinah and Yanbu have a total daily capacity of 25 million gallons. The plants at Al-Wajh, Duba, Al-Khafji, Aumluj, Farasan, Haql, Rabigh, Al-Bark and Assir together have a daily capacity of approximately 36 million gallons.

So the rated capacity of desalination plants in the Kingdom has grown from 5.1 million gallons per day (mgd) in 1970 to 512.2 mgd in 1996, which is an annual growth rate of 24.3 percent.

3.4 Agriculture

Although much of the land in Saudi Arabia is desert, it is not infertile. With sweet water (the ground water towards the east of the country is becoming increasingly saline), the land can produce much. Agriculture has the second greatest requirement for water after domestic consumption. The Saudi government has undertaken extensive irrigation projects, involving the production (pumping and desalination), storage (in reservoirs), distribution (through pipes and canals), and modernisation of the means used to apply water to crops. As a result of careful planning and the implementation government policy, considerable progress has been made in bringing Saudi Arabia towards agricultural self-sufficiency.

Private sector agricultural companies were set up to enhance agricultural products and to encourage private investment in agricultural and animal production. The Grain Silos and Flour Mills Organisation bought locally-produced wheat and barley at prices profitable for the farmers. The Saudi Arabian Agricultural Bank (SAAB) total short-term and medium-term loans rising from SR 16.6 million in loans in 1970 to

SR 2.3 billion in 1984, then declined gradually to SR 412.6 million to the end of 1995 (Ministry of Planning, 1996).

The government has given support to the agricultural sector in several ways. Over 1,500,000 hectares of agricultural land were distributed to farmers and agricultural companies and seeds and plants were sold to them at subsidised prices. They were provided as well with agricultural advice, veterinary assistance and agricultural pest control services. Up to 50% of the cost of fertilisers was met by the government and 45% of the cost of equipment and pumps. Agricultural roads were built, as were, approximately, 200 dams, with a water storage capacity of around 450 million cubic metres. An agricultural bank was established in 1964 to provide long-term and interest-free short loans

There was a rise in total wheat production from 26,000 tons in 1970 to more than 4.2 million tons in 1992. Wheat production has since been reduced, and the production of barley, vegetables and fodder have been expanded, in order to diversify agricultural production. Date production has increased from 240,000 tons in 1970 to about 700,000 tons in 1992. The increase in fruit production rose from 470,000 tons in 1980 to 792,000 tons in 1991. The annual production of broiler chickens for slaughter is 2.7 million tons, and the annual production of eggs is 1.3 million tons. The slaughter of fish and crustaceans amounts to 50,000 tons, with any surplus being exported to the United States and Japan.

All the above economic development sectors needed healthy manpower to be able to improve national and global development. Public health administration is required not only to manage hospitals, but also to manage environmental health.

3.5 Mineral resources

Saudi Arabia is rich in mineral resources. Most significantly it has an estimated one-quarter of the world's oil resources. Other minerals include gold, silver iron, copper, bauxite, zinc, nickel, phosphates, magnesium, gypsum and salt.

Until the discovery of oil, the Arabian peninsula was considered of relatively slight economic worth to the world's political powers, such as Britain, France, Germany, Russia and the United States. International competition for Arabian oil transformed indifference into intensive diplomacy: each power competing against the other. Oil resources transformed the former Muslim notion of a shared land inhabited by itinerant nomads into a finely delineated patchwork of sovereign states (that sovereignty tested by a sequence of confrontations, the latest of which was the Iraqi invasion of Kuwait). The oil resources brought huge trans-national corporations to the Arabian peninsula, and particularly to Saudi Arabia, along with vast numbers of expatriate workers from alien cultures, the main problems being workforce shortages, and the reluctance of Saudis themselves to engage in what they consider to be menial tasks (Hickson and Pugh, 1995). Most significantly, with high production rates and negligible consumption, the oil resources brought unimaginable wealth.

The revenue from the exploitation of its vast oil reserves, has been used to finance the country's economic and social development, including education and health facilities, from near non-existence to some world-class facilities.

3.6 Industry

There are several reasons why it is important to consider the impact of industry on public health. On the positive side of the health balance sheet, there is the generation

of wealth (with which to pay for health care provision), and the future prosperity (with which to maintain provision) promised by economic development plans which have consistently focused on industry. The Saudi government has been intent both on diversifying its income away from a critical dependence on oil, and also on building an economic infrastructure less dependent on goods and services from beyond its borders, that is, to become more self-sufficient. More subtly, perhaps, the development of industry has been instrumental in developing and expanding management expertise in Saudi Arabia, which has some bearing on how the public hospitals are managed.

There are also negative effects on health. Overtly, petroleum refineries cause industrial pollution; industrial plants are dangerous places where people get injured; and transportation of industrial goods almost inevitably leads to more traffic accidents. Second, the development of industry has competed with the development of health care provision, not just in terms of government funding, but perhaps more significantly in terms of labour and expertise. Third, the development of industry has brought into the country many more expatriates, with their own health care needs and expectations.

The government has placed great importance on industry from the beginning of the First Five Year Development Plan. The government's commitment to establishing a diversified industrial base is reflected in the transformed of desert into two industrial cities at Jubail and Yanbu, and in the establishment of eight industrial quarters, situated in Riyadh, Jeddah, Dammam, Al-Qassim, Al-Ehsa and Makkah.

The industrial cities of Jubail and Yanbu were established in 1975. Jubail is located on the east coast, and Yanbu on the west coast. They accommodate the industrial

facilities of the General Petroleum and Mineral Organisation (PETROMIN) and Saudi Basic Industries Corporation (SABIC). These twin industrial cities were expected to meet 5-6 percent of the world demand for petrochemicals (Ministry of Planning, 1996). The Al-Jubail industrial city has established a residential district with houses (11,338), schools, and 26 mosques. The district has full infrastructure facilities, such as water, sewerage, electricity, roads, medical and educational facilities. The medical facilities include two hospitals, each with 200 beds, and three clinics. The city has an industrial training college for Saudi nationals, with capacity of 1200 persons per year. Similar facilities can be found in the industrial city of Yanbu. These cities serve to reduce Kingdom's reliance on oil revenues as the main source of income. Both the manufacturing industry and the basic industry have benefited from the development plans.

The decline in oil revenues in the 1980s accelerated the programme of diversification into industry and commerce. The manufacturing industries were established mainly by the private sector, with government support. The number of factories in operation multiplied ten-fold, from 199 in 1970 to 2,036 in 1992. Capital investment in the factories rose from SR 2.8 billion in 1970 to SR 138.5 billion in 1992 and an increase in the number of employees during the same period from 14,000 to 175,000. Exports reached SR 3.5 billion. There was in increase in total loans extended to industrial projects from SR 85 million in 1974 to SR 15.12 billion.

3.7 Population

In 1996 the population of Saudi Arabia was 19,344,556, of whom 14,179,156 were Saudi nationals. From Table 3.1 it can be deduced that, whilst numbers of male and female Saudi nationals are roughly equal, 70 per cent of expatriates are male; and

that this latter proportion (male:female) has remained similar from 1994-1995, as have the numbers.

Table 3.1: Population of Saudi Arabia

Population		1996	1995	1994
Citizens	Male	7,097782	6,851511	6,612232
	Female	6,991374	6,741938	6,499260
Non Citizens	Male	3,666193	3,649812	3,602596
	Female	1,589207	1,558327	1,517702
Total		19,344,556	18,801,588	18,231,791

Source: G.C.C. Statistical Bulletin, (1998:3).

The Government of Saudi Arabia had to import the services of expatriates to enable it to carry out its development plans and even to instigate them. While, as could be expected, the country needed experts to satisfy its industrial, agricultural and health requirements, at the same time vast numbers of non-nationals were encouraged to come to Saudi to perform tasks which the Saudi people were unable or unwilling to perform. Tables 3.2 and 3.3 show the number of Saudis citizens and non-Saudis according to sex and administrative area, and Table 3.4 non-Saudis in the same categories. As described later, this influx of foreigners has not been without problems related to health (unaccustomed to the heat and humidity, in some areas), different food and the culture.

Table 3.2: Saudi National Population by Sex and Administrative Area

Administrative Area	Saudi		
	Male	Female	Total
Makkah	1400917	1380158	2781075
Riyadh	1341594	1272321	2613915
Eastern	987301	914807	1902108
Aseer	565906	584183	1150089
Madinah	416686	421009	837695
Jizan	359461	374507	733968
Qassim	303290	307276	610566
Tabuk	210579	191338	401917
Hail	169683	176494	346177
Najran	119981	120600	240581
Baha	135796	154150	289946
Jawf	112403	111003	223406
Northern	92196	86414	178610
Total	6215793	6094260	12310053

Source: Statistical Yearbook, 1996.

When the above table is examined it can be seen that Makkah, Riyadh and the Eastern Region together contain the majority of the Saudi population and that in the latter two regions males predominate over females. The reason could be that males tend to come into the cities from the rural areas to seek employment more readily than females do and, also, that males wishing to obtain more sophisticated employment need to come into the urban areas.

Table 3.3: Non-Saudi Population by Sex and Administrative Area

Administrative Area	Non Saudi		
	Male	Female	Total
Makkah	1096806	589789	1686595
Riyadh	881909	339162	1221071
Eastern	516123	157589	673712
Aseer	146579	43500	190079
Madinah	171759	75493	247252
Jizan	84303	47690	131993
Qassim	111845	28568	140413
Tabuk	62560	21657	84217
Hail	50522	14585	65107
Najran	41944	18469	60413
Baha	32083	10128	42211
Jawf	33699	11123	44822
Northern	34048	16402	50450
Total	3264180	1374155	4638335

Source: Statistical Yearbook, (1996).

What is striking from the above table is the number of non-Saudi males compared with non-Saudi women who come to work in the Administrative areas. In some cases, fore example: Riyadh, Makkah, the Eastern region and Qassim, the figures are dramatic. This is the opposite of the case shown in Table 3.3. The reason could be that, except in the case of nurses, men, predominantly single men from countries where unemployment rates are high, are attracted and encouraged by the Saudi Government, which is short of workers to work on contracts in Saudi Arabia.

Riyadh, the country's capital, is located in the central region (Najd), and accommodates virtually all the central offices of national government ministries and agencies. The population tends to be concentrated in towns and cities, so it is there that public services for wide areas are situated. Therefore the distance between source and distribution point can be considerable and creates problem for the rural people. Another factor that has a significant effect on Saudi health services is the annual flood of up to two million pilgrims to the holy cities of Makkah and Al-Madinah, which lie in the western region of Hijaz (Table 3.4).

Table 3.4: Pilgrims from Inside and Outside Saudi Arabia, 1982-1996

Year	From Inside	From Outside	Total
1982	1158000	853555	2011555
1983	1497795	1003911	2501706
1984	744807	919671	1664478
1985	738015	851761	1589776
1986	743757	856718	1600475
1987	658938	960386	1619324
1988	616801	762755	1379556
1989	692435	775460	1466995
1990	817234	827236	1644470
1991	908084	720102	1628186
1992	856138	1322003	2178141
1993	994835	1040540	2035375
1994	536070	997436	1533506
1995	490861	1046307	1537168
1996	526170	1083252	1609423

Source: *Annual Health Report*, 1996, p.272

Whilst the number of pilgrims from inside the Kingdom dropped by over 45% between 1982 and 1996, pilgrims from outside the country increased by 27%. Table 3.1 shows that the numbers in both categories fluctuate greatly, which means that the

total number of pilgrims can vary between 1.4 million in 1988 and 2.5 million in 1983. This fluctuation makes planning for the health services difficult, and necessitates preparation of significant provision of health services for between two and four months, thus putting considerable strain on the country's medical facilities.

The existing concentrations of population and public services, and the export of oil, all have an impact on public health policy, which is committed to delivering 'health to all', both to Saudi nationals and to non-nationals, first initiated in 1926 (Mufti, 1999).

The relatively short existence of Saudi Arabia as a state, and the even shorter period of time during which a public health policy has existed, denies Saudi Arabia a firm historical basis on which to build health service provision. Moreover, none of its immediate neighbours have much more experience of public service provision than Saudi Arabia. This means that Saudi Arabia must look further abroad for models of development, particularly for the development of its public and private health management services, health facilities and medical manpower.

The Kingdom is divided administratively into several regions (Table 3.3 and Figure 3.1). Although south west Saudi Arabia is most populous, service provision is intensified in the central region, around Riyadh. Other strategically important regions with major cities include Makkah and Madina (cities of pilgrimage) and other holy places (see below in this chapter regarding the health care requirements of pilgrims), Jeddah, Jizan and the Eastern Region, with its oil capital, Dammam.

Table 3.5: Regions of Saudi Arabia

Region	Capital
Riyadh	Riyadh
Makkah	Makkah
Medina	Medina
Eastern Region	Dammam
Al-Qassim	Buraidah
Assir	Abha
Tabuk	Tabuk
Hail	Hail
Northern Region	Arar
Jizan	Jizan
Najran	Najran
Al-Jouf	Sakaka

These regions are disparate in size and population, making the provision of health services appear quite patchy. The text below offers a sketch of some of Saudi Arabia's main cities.

3.7.1 Riyadh

Riyadh is the capital city, and largest city, in the Kingdom. Government ministries, central government authorities, embassies and the diplomatic corps relocated here from Jeddah in 1970. Riyadh is now the centre for the scientific, financial, industrial, agricultural and commercial institutes and corporations, as well as social, cultural and artistic institutions and societies. It covers an area of 1600 square km, with a population in excess of two million. According to the Annual Health Report (1996) 27 Ministry of Health (MoH) hospitals, with 4,835 beds, are located in Riyadh.

3.7.2 Jeddah

Jeddah, the second largest city, is the main Saudi seaport on the Red Sea and the gateway to the two Holy Mosques. It has an area of 1200 square km and a population exceeding 1.5 million. Jeddah remains an important industrial and commercial city. It has 11 MOH hospitals with total of 2,894 beds (Annual Health Report, 1996).

3.7.3 Makkah

Makkah is the birthplace of the Prophet Mohammad and the spiritual capital of the Kingdom. Every year it is visited by around two million Muslim pilgrims (Table 3.4) from all over the world, that come to perform the pilgrimage. Health care for pilgrims in Makkah has been a significant aspect of the development of Saudi health care services, which has 7 MoH hospitals with total of 2,049 beds (Annual Health Report, 1996).

3.7.4 Dammam

Dammam, the largest city in the Kingdom's Eastern Region, has a population of approximately one million. It is an important oil city and seaport located on the Arabian Gulf. It has developed rapidly and has expanded to connect with Dhahran and al-Khobar. The 13 MOH hospitals have a total of 1,792 beds (Annual Health Report, 1996).

Each of the regions, with its major cities, is governed locally, but reports to central government in Riyadh. Social service requirements and developments must pass through central government, which sanctions the necessary capital (Al-Tawil, 1995)

3.8 Transport communications

The comprehensive development of transport infrastructure is important for the health care staff, and patients, to have easy access to hospitals. It also can increase the economic development of the country, especially as prior to the exploitation of its oil resources the country was undeveloped industrially. Furthermore, the topology of a transport infrastructure can dictate both the pattern of movement within a country, and, therefore, the location of services such as health and education, and the type of economic activity in which the country can engage. For instance, in Dubai, priority has been given to the development of entrepot commerce, and the development of highways has been of lesser importance. Therefore, health facilities in towns have been developed in the context of their under-developed transport link with Dubai city. When considering Saudi Arabia, the location of general health facilities, whilst determined by a policy focusing on making certain facilities available per thousand of the population, will have been influenced by accessibility in terms of travelling time. In a different sense, too, the pattern of development of the transport infrastructure has determined where the population, requiring services such as health facilities, have located themselves. The most obvious example is Riyadh, which without the development of its links with existing towns and cities, would not exist as a major city today.

Roads: Roads are the major paths for reaching health facilities. Travelling time is sometimes critical in emergency cases obviously requiring immediate care, and maybe special care either locally or at hospitals some distance away. A smooth ride is also vital for critically ill patients. The total length of inter-city paved roads increased from only 35,000 kilometres in 1970 to 99,000 kilometres by 1995 (Achievements of the Development Plans, 1996). The majority of cities and towns

are now linked by roads of at least two lanes. During the same period the network of earth-surfaced roads in rural areas increased from 35000 kilometres to 93,000 kilometres. The cost of those roads had reached over SR 120 billion. The improvement in the road system (see Table 3.6) and the road surface quality, has led to an increase in the number of vehicles using the roads, and, consequently, the number of road accidents (see Table 3.7). This latter has an impact on hospital admissions and life prospects of patients, which not only effects health costs but, also, economically in that important personnel may be lost as far as national human resources concerns.

Table 3.6: Road building in KSA in ('000 kilometres)

Year	1970	1978	1983	1985	1987	1990	1993	1995
Length of road constructed	35	20	43	58	67	78	90	99

Source: Achievements of the Development Plans, 1996:179

The road building can be seen to have increased nearly three-fold. In view of the development of the country this does not seem to be a dramatic increase. However, it is not possible from this table to discover how much is new road building rather than improving existing roads to meet modern transport requirements.

Table 3.7: Traffic Accidents in K.S.A. (collision, trampling, over-turning)

Traffic Accidents	1996	1995	1994
Accidents	167,265	122,140	125,324
Main paved roads	36,581	36,150	34,555
Vehicles in use	6,333,873	6,111,137	5,861,614

Source: G.C.C, Statistical Bulletin, 1998

Table 3.7 shows that over the three year period, there was a dramatic rise in accidents. Whether this is due to poor driving standards or to the nature of the roads cannot be gleaned from this table. By 1999, car accidents and careless road crossing by pedestrians had increased the death and injury rates dramatically. In fact, 40% of car accidents resulted in death; these were of cars which actually turned over injuring people in them and pedestrians, and 7% of accidents were caused by animals straying onto the roads (Al-Ghamidy, 2000). The huge number of injuries caused by road traffic accidents places a burden on Saudi hospital services.

Railways: The number of railway passengers increased from 3.8 million in 1970 to 169 million in 1996. In 1951 King Abdulaziz opened a major rail connection between Riyadh and Dammam. There are two trains daily between Dammam and Riyadh, a journey of four hours. The railway system is being expanded and made more efficient between the Eastern regions with Riyadh now having a new dual line now connecting the eastern with the central region. It is hoped that the increase in railway development and use will, in consequence, reduce or curtail the rising number of vehicles on the roads and accident and death rates associated with them.

Seaports: The increasing development of seaports have put a considerable strain on the health facilities of the ports and nearby hospitals are importantly needed, for as well as physical injuries to workers on the dockside and aboard ship due to accidents there was a need to perform preventative measures to cope with infections and diseases contracted abroad and with the hundreds of thousands of pilgrim each year arrive by seaports. Major hospitals had an increasing number of in-patients with a variety of life-threatening diseases contracted abroad by pilgrimages and ships' personnel, when they returned to Saudi Arabia. The total number of Saudi maritime shipping companies is 114; between them these companies own eleven liners. In

1975 there were 27 berths in commercial ports; this number increased to 179 berths in 1992-93. The value of cargo handled increased from 1.8 million tons in 1970 to 79.4 million tons in 1995 (Achievement of Development Plans, 1996).

Air transportation: An increase in traffic from all types of air and land transportation has placed a strain on the health services the burden not only of dealing with injuries resulting from accidents, but also the health needs of a huge number of visitors and nationals being abroad, as not all of which arrived in Saudi Arabia from abroad are in good health.

The Kingdom's national carrier is the General Organisation of Saudi Arabian Airlines (SAUDIA), which operates 111 airliners. SAUDIA employs more than 10,000 people, 1,000 of whom are pilots. This was a remarkable development during the previous Five Year Development Plan, the number of passengers carried, increased steadily from 0.6million passengers in 1970 to 12million passengers in 1995, representing an average annual growth rate of 12.2 percent, with the aim of eventual privatisation.

There have been 25 airports built by the government. Three of these are international, 14 are domestic and the remaining 8 are regional. King Khalid International Airport in Riyadh was opened in 1983. It is located 35 kilometres north of Riyadh and covers 225 square kilometres. It has an annual operational capacity of 7.5 million passengers. Dhahran International Airport in the Eastern Province occupies an area of 780 square kilometres. This will be replaced by King Fahd International Airport, which is currently under construction in Dhahran. King Abdulaziz International Airport in Jeddah was opened in 1981, covering an area of 105 square kilometres.

3.9 Communication and information systems

Modern communication is a valuable asset for health awareness programmes, originally designed to educate people, especially pregnant mothers in ante- and post-natal care and children's illness and the need for vaccination against them. Later these were extended to give instruction on how to cope with accidents and show simple remedies for use in the home, and, also, adult illnesses. The aim was both to educate and reduce the unnecessary pressure on medical facilities designed for more serious illnesses. Advertisements from local and international companies have dispatched information regarding product availability.

Saudi communications systems have progressed considerably in both quality and reliability, which now compare favourably with those of the most advanced industrial nations. A satellite earth station was built in 1976 to link up with Indian Ocean Satellites, followed by another in Taif to link up with Atlantic Ocean Satellites. Each initially held a capacity of 72 circuits, which was expanded to 234 circuits. Through these the Kingdom is connected with 20 countries. Prior to this 11 earth stations had been built to service major cities in the Kingdom, with five more established to serve in emergencies. These were later replaced by microwave and axial cable facilities.

King Fahd City for Satellite Communication is the biggest of its kind in the Middle East. It is located between Jeddah and Makkah and occupies more than one million square metres. Built in 1988 it includes four earth stations connected with 200 countries. The ARABSAT earth station connects the Kingdom with Arab countries, with a capacity of 850 telephone circuits and facilities for TV transmission by means of an aerial with a diameter of 32 metres. The Indian Ocean Satellite Earth Station is

located within the range of the Indian Ocean satellite, with a capacity of 1300 telephone circuits and facilities for TV transmission, again with an aerial of 32 metres diameter. The Atlantic Ocean Satellite Earth Station connects the Kingdom with the Atlantic Ocean Satellite and has a capacity of 1,400 telephone circuits. It has facilities for TV transmission via an aerial with a diameter of 32 metres. The International Maritime Communication via Satellite (INMARSAT) provides communication with mobile objects on sea, in the air and on land. It is connected with the INMARSAT satellite (*Saudi Arabia: Landmarks of Progress*, 1994). This has made medical development in communication with local and overseas consultations and medical operation easy to reach by patients in the Kingdom.

The Ministry of Information is responsible for radio, television and the press and regulates the dissemination of information to citizens in a manner which safeguards Islamic values and conforms to the Shari'a. Information and news is provided to the public through radio and television and through the distribution of printed matter such as books. In collaboration with other government agencies, the Ministry of Information undertakes, by using television, radio and press journalism, to convey information regarding news items and cross-cultural events, health awareness, and safety programmes.

Radio: Radios are decreasing in cost and so are much cheaper than television for health education programmes uses. This makes health programmes accessible to an increasing number of educated and not educated people regarding their heath matters. Entertainment, knowledge, information and news are of enormous benefit to ex-patriots who can keep in touch with events at home to also relieve homesickness types. Short wave radio is invaluable for police, fire and ambulance services, all

these high-tech could be aimed to reduces number of patients and increases health awareness programmes.

In 1948 transmission commenced from Saudi Radio Broadcasting Service's Jeddah radio station. Its transmission covers three continents and has three overseas programmes, which are broadcast in ten languages. By 1992-93 the number of radio stations had risen to 22, broadcasting programmes through five main radio broadcasting services. These were: the Holy Quran Service, the General Programme Service, the Islamic Call Service and the Overseas Programme Service. It also has 16 FM stations. More than 85 hours of radio transmission is broadcast in the five services in English, French, Turkish, Persian, Urdu, Bengali, Turkistani, Swahili, Somali and Pamparari. So it has recently been used for Broadcasting health service before people coming to the Hajj Season.

Television: The Health education programmes by television not only inform and have education programmes but also enable people to observe others with similar problems, roads' accidents and to learn from experts how to cope in certain illnesses such as cold coughs and other simple health difficulties. For people with a low standard of education, visible information is superior to verbal information. Viewing patients in hospital situations is designed to reduce the fear of medic operations, being admitted to hospital and what can be done for people in life threatening situations.

In 1965 the television transmission services started in both Riyadh and Jeddah with Channel One, which broadcasts in Arabic. In 1983 Channel Two began transmission to 42 television centres; this channel broadcasts in English and French. By the late 1990s the number of channels increased dramatically by the use of satellite dishes.

Developments of stations have spread television transmission throughout the country. Television is of tremendous value in spreading information and enabling people to view events and personalities and keep them in touch with new advances in science.

The Ministry of Information operates thirty local information offices. Eight information centres and nine centres for foreign information are located in the Kingdom. The Saudi Press Agency (SPA) operates six offices abroad and has correspondents in six world capitals, and four main local offices and correspondents in five major cities.

The pictures and films of vehicle accidents are not only of dramatic interest, but can serve as warnings to drivers and pedestrians of how easy accidents, often very serious, can occur. Al-Rubaish, (2000) stated that 60% of traffic accidents die later in hospitals. Total cost of a young death person may reach SR 400,000 which was the educational, health care and living cost, if under 20 years old knowing that 50% of traffic accidents are under 20 years of age, Al-Araifi, (2000). The yearly statistics shows that 250,000 accidents, 4,000 death cases, 30,000 injured and 2,000 disables, Al-Subai, (2000). It is hoped that by showing these, a reduction in accidents and the lowering of the death rate can occur and, also, the strain on the Health Service will be reduced. Therefore, health administrators would reduce health cost when using health education programmes.

The Press: Another way in which the press and, of course, the television and radio serves as an aid to health awareness is when it describes and illustrates the horrendous, newsworthy, accidents which occur both in the home, where serious injuries are caused by careless use of solvents which result in serious burns and

complete homes being gutted, and in road accidents. By reporting road accidents in full and illustrating the reports by photographs and diagrams, people are made aware of how easy it is to have a serious accident through speeding, loss of concentration and poor knowledge of coping with various road conditions and lack of consideration for pedestrians and animals: 70% of traffic accidents were caused by drivers' lack of consideration for pedestrians and other vehicles (Al-Rubaish, 2000).

The press is an easy and cheap way of communicating. Even semi-literate people can gain formation from simply-worded headlines and photographs and diagrams. As for its role in the health of the population at large it is a valuable tool. Articles relating to illness, compiled by doctors and advertisements relating to home and locally obtained medicines, in particular, analgesics, are of value. Ten daily newspapers are issued in Arabic and three in English, as well as weekly magazines and over one hundred periodicals.

What the above accounts suggest is that developments in transport roads, vehicles, ships and aeroplanes - have led to an increase in risks to health and have, consequently, placed a great strain on the health services of the country through having to cope with ever increasing accidents and illnesses. Both the government and private agencies encouraged by the government, have sought to alleviate the situation. Building hospitals and increasing the number of doctors is not the complete answer. Therefore, the government has instigated a number of health awareness programmes through the use of the media. Radio, television and the press are involved in educating the public through a series of programmes that include information from health and safety experts. With television, people can see new advances in medicine and other forms of health care; can see what takes place in

hospitals (of particular use to nervous people are the 'before' and 'after' views of patients who have undergone surgery for genetic illnesses).

3.10 Summary

The terrain, climate, resources, industry and demography of Saudi Arabia have been described in detail, in order to give the context in which public administration and health care provision have developed. Each of these factors has impacted both in terms of opportunities and constraints. For instance, it has been shown that Saudi Arabia, with its relatively small indigenous population, has historically had neither the home-grown expertise to set up and administer the huge commercial and social infra-structure typical of an economically-developed country, nor the raw manpower to carry out much of the labour. These demographic short-comings have shaped the development of public administration of Saudi Arabia. Further, it is only as a result of its vast oil resources that Saudi Arabia has been able to implement the growth of its public administration. The limited life of the oil resources have pressured the Saudi government, through a series of Five Year Development Plans, into economic diversification, involving the development of a range of industries.

Chapter Four

Public Administration in Saudi Arabia: Rationale and Development

4.0 Introduction

This chapter considers aspects of public administration in Saudi Arabia with three focuses. First, public administration is placed in an overall financial context, recognising that in order to disburse money, a government must create the bureaucratic framework from which to do so. Second, the structure and provision of social welfare in Saudi Arabia is considered, in part as an aspect of government-funded social development, and in part to give a context from which to examine health care. Third, the structure, development and provision of health care in Saudi Arabia is considered in some detail.

4.1 Public administration development expenditure plans

Saudi public administration has become larger in size and more complex in its policies and procedures by the acceleration of oil revenues. Since 1970, the Saudi government has been intent on developing the country economically, commercially, industrially and socially. To achieve these developments, public administration has drawn up progressive development expenditure plans.

Table 4.1 shows that there has been a dramatic rise in government expenditure on public health sector as well as or even more than other public services. The government has been able to do this mainly because of the worldwide demand for its oil.

Table 4.1: Saudi Five Year Development Plans

Government Five-Year Plans	C.E.	Government expenditure (SR billions)
1st	1970 - 1974	6.1
2nd	1975 - 1979	188.4
3rd	1980 - 1984	216.4
4th	1985 - 1989	149.5
5th	1990 - 1994	160.0
6th	1995 - 2000	328

Source: *Achievement of the Development Plans*, 1996.

The first Five Year Development Plan began in 1970 with a budget of SR 6.1 billion. It aimed to implement infrastructure projects relating to roads, seaports, airports, public utilities and services, and provided a model for subsequent Five Year Plans. Government expenditure increased continuously. The dramatic increase in the budget of each development plan was due to oil revenues, as well as to non-oil receipts such as telephone, telex, customs duties, port services, airport fees and fees levied on the sale and lease of property steadily increased from SR 18.2 billion in 1984 to 29.3 billion in 1992 (SAMA Annual Report, 1992). This huge increase in receipts has enabled the Saudi government to spend generously on health care for its population.

4.2 Public administration policy

The policy of public administration in Saudi Arabia is based on the Holy Quran and the Prophet Mohammed's saying and behaviour (the Islamic law) formed by the *Shari' a*, Al-Saud, (2000).

The King holds supreme executive and legislative power, and is assisted by an appointed cabinet. Whilst there is no parliament, ninety selected Councillors look after government affairs. Since 1984, all central ministry headquarters have been located in the capital, Riyadh, when they were transferred from Al-Hijaz province. The Council of Ministers was formed in 1954, and was expanded in order to meet modernisation needs.

The liberal economic system and its high volume of investment in various production sectors the country's economy is strong due to both its oil-sector and non-oil-sector revenues. Regarding Saudi Arabia's oil sector production, export revenues show an increase in crude oil and natural gas from SR 92,800 million in 1974 to SR 146,984 million in 1994; petroleum refining from SR 5,129 million in 1974 to SR 15,689 in 1994; and regarding non-oil sector revenues: private sector revenues from SR 14,192 million in 1974 to SR 168,398 million in 1994; and from the government sector was SR 7,572 million in 1974 to SR 115,616 million in 1994 (Ministry of Planning, 1996). Producer prices grew at an average annual rate of 8.5% (ibid:112). This is greater than that of any other Middle Eastern country. Preparations are also under way to commence more gold production from the Mahd al-Thahab (gold mine), which contains proven reserves estimated at 4.59 million ounces. The Saudi Riyal is among of the strongest world currencies. In order to decrease the Kingdom's dependence on oil, the government has been promoting the establishment of heavy industries.

Initially, oil production and sales were contracted out because of a lack of skilled manpower, generating an excellent income for use in government expenditure on modernisation. Hospitals and medical centres were established, managed, and operated by contracted architects and builders, and were serviced by foreign medical

companies (under contract), while Saudi staff were to be trained by these foreigners (Viola, 1986). Schools and educational institutions were constructed, providing people with the chance to educate themselves, the Saudi government bearing the costs of buildings, teachers and books. University students also receive income support. The national provision of roads, electricity, water and communications was also contracted out to local and international private agencies, due to the shortage of educated and skilled Saudi manpower. Teachers, administrators, and skilled and unskilled workers, were recruited from all over the world to help develop the infrastructure of the Kingdom. It is obvious, therefore, that provision of services and personnel by contract has been vital for the structural development of the country.

4.3 Economic policy and its development

An important change in the national economy in the 1980s was the emergence of the view that the state should do less and the private sector more. It had always been central to Saudi development plans that private business should play a substantial role in the economy. Saudi Arabia's economy is based on free and private enterprise. A variety of its products were exported to more than 70 countries. In 1992 the gross domestic product (GDP) stood at US$ 112.98 billion. The non-oil sector's share increased from 46 percent in 1970 to 67 percent in 1992. In 1992, the private sector produced 44.26 billion dollars of goods and services (Ministry of Information, *Facts and Figures*, 1996). Even so, the private sector remains a minor part of the Saudi economy. In most advanced economies, manufacturing accounts for at least 20 percent of GDP. In 1991, the contribution of manufacturing to Saudi GDP was less than 8 percent. Saudi Arabia appears to have moved directly from an agricultural-based economy to a service economy. Many of the young Saudi Arabian people being trained for work in administration, management and the professions are the

children of people who lived off the land, not factories (Edmund O'Sullivan, 1993:75). Therefore, they have family history of such occupations and often lack the encouragement and support of their families when seeking or undertaking such roles, (Hickson and Pugh, 1995).

Two economic principles are crucial in the economic and social development of Saudi Arabia. First, the Islamic Shari'a, and traditions that foster freedom for individuals to engage in economic activity of their own choice. Second, the free market economy, with free access for all individuals and groups, as stated in development plans and guaranteed by the state (Ministry of Planning, 1995).

Whilst the Shari'a has a major historical significance for Saudi Arabia, there are tensions between Shari'a and the global free market. On the one hand, Shari'a is formally based on religious writings and considered neither subject to interpretation, nor variable, and prospective innovations are tested in a Shari'a court. Furthermore, the King, his representatives, and, therefore, government agencies, are inseparable from Islam. Therefore, the Shari'a has considerable significance for Saudi commercial dealings as usury is prohibited. Banks lend money to business on a 'profit and loss' sharing basis. This huge financial system is compatible with either private or State ownership of business organisations (Hickson and Pugh, 1995). The economic conditions of a country not only operate within the country's legal environment, but are also determined by that legal environment. The extent to which free enterprise can succeed within any one society depends upon the extent to which the legal framework exists to permit or restrict the operation of that free enterprise economy.

In order to achieve economic development, the public administration of Saudi Arabia has had to diversify the economy from oil production and refinery products, to industrial plants and factories producing steel, fertilisers, petrochemicals, cement, glass and plastics, to be exported to other countries. In order to support this, the country has had to develop advanced banks, transportation, roads, seaports and other public facilities.

4.3.1 Banks

Development banks and funds have received special attention from the government, with a view to improving the standard of living of citizens. Individuals and investment firms have received short-term, medium-term and long-term loans and subsidies. The Saudi Credit Bank, which was established in 1971, has 24 branches throughout the Kingdom. Between 1971 and 1993 it provided 315,351 loans – a total of SR 4,497,387,157. These loans were provided for various purposes, including: marriage, housing renovation, small craft businesses, medical treatment and professional development. The Saudi Agricultural Bank was established in 1962 and has provided subsidies which rose from SR 43.3 million in 1974 to SR 1.4 billion in 1995 (Ministry of planning, 1996) to farmers for agricultural projects. The Real Estate Development Fund was established in 1974 and by 1990 had provided 365,412 loans totalling SR 96,890 million to build housing units. During the same period 2,472 investment loans were given totalling SR 5,170,000,000. The Saudi Industrial Development Fund, which was established in 1974, supports industrial development in the private sector. The end of 1992-93 there were 1,216 industrial projects had established from loans provided by this fund, amounting to SR 21.7 billion. The Saudi Development Fund (SDF) was also established in 1974 and has provided funding for development projects in underdeveloped countries. The

Kingdom provided US$ 67.7 billion in soft loans to underdeveloped countries between 1975 and 1992. This money was used in development plans and reconstruction projects. In 1992 seven development projects in five developing countries benefited from loans provided by the SDF, which amounted to SR 382.1 million. This greatly speeded the growth of establishing developing the private sector.

4.4 Privatisation policy and its development

Since 1980, privatisation has been a major policy issue in the public administration development plans. The Saudi government proceeded with privatisation programmes, and declared that privatisation was to be a major theme of the Sixth Five Year Development Plan (1995-2000). The rapid growth in manpower demand has strained the capacity of educational and training institutions to keep pace with the expansion of health services. The need for new programmes at medical colleges, the establishment of new intermediate polytechnic Health Colleges, affiliated to the Ministry of Health, and instigating licences for practising health professionals is great. It was held, therefore, the private sector should be considered to supplement the State sector in order to increase health manpower and to encourage diversity and specialisation, and to upgrade efficiency.

Prior to 1980 the Saudi economy was dependent almost exclusively on oil export, so the government led the developments of its national economy. Not only did the government own most of the means of production, such as steel mills and cement factories, but it also determined all public development services. As a process for the development of a single income economy into the diversified economy that it became, government ownership was effective. However, state-ownership of

enterprises is no longer considered to be a mechanism for growing an international economy. Accordingly, the Saudi government has been attempting to develop the private sector. This has involved encouraging new enterprises, and privatising participation, that is, contracting-out public-sector management and services.

Therefore, strategic objectives for the public administration Five year Development Plans aim to increase private sector participation in socio-economic development, encourage the industrial sector to adopt Research and Development (R&D) policies and assist in establishing research laboratories. Also, to enhance science and technology support services and establish appropriate mechanisms for sponsoring research and development results and risk sharing was the aim of the Sixth Development Plan (1995).

> More support will be extended to the private sector to enable it to undertake a greater role in the Kingdom's comprehensive development and to encourage it to invest in establishing, operating and managing some government's projects (ibid).

The health of the Saudi Arabian population has gained considerable advantages from the development of the country's easier access to health care through road development, the building of clinics, hospitals and increasing the number of doctors and paramedics; the availability of a good food supply and, of prime importance, a vast improvement in the supply of water for human consumption, irrigation and industry. This, in the main, has been made possible by the development of Saudi's oil resources and finance schemes to bring in expatriate experts where necessary.

4.5 Education and social development

The character, customs and traditions of the Saudi people have been formed by the life of the desert and life under Islamic tradition. The traditional values of a conservative society, including a belief in its own liberality and generosity, early marriage, and a concern for family values and family roots, are still important to the people, despite the modern city life enjoyed by many men. As is the case in many conservative societies, gender role differentiation is pronounced and celebrated. Men and women chose to believe that women prefer not to work outside the home, so they can take care of their children and aged parents (Al-Nughimshi, 1997). That there are other Islamic societies, such as parts of Iran, Iraq and Afghanistan, in which women achieved some freedom to work outside the home (although are now being compelled by men to return to domestic obscurity) is not practised in Saudi Arabia. Nonetheless, Saudi girls are given a good education.

Health and education are the main developmental priorities of the Saudi government. There are two major reasons for this, including

1. It is not possible to operate an advanced economy without a healthy and educated workforce;

2. It is not possible to develop the country political, social, economic and industrial infrastructure without an educated and enlightened workforce.

However, Saudi Arabia has been required to buy in vast amounts of expertise from overseas, and it is now a clearly identified governmental policy to shift the balance towards the employment of Saudi nationals (Saudisation), which requires the

development of 'home-grown' talent. These issues also apply to health sector development.

Education has developed rapidly since 1953 when the Ministry of Education was established, with Prince Fahad as the First Minister. He established the country's education system, which has continued to develop into an excellent educational infrastructure providing primary, intermediate and secondary schools and technical and vocational schools, colleges and universities.

In 1969 the total number of students enrolled in all educational establishments was 547,000; this number rose to approximately 4.5 million by 1995. The average annual increase for boys was 6.3% compared with 10.7% for girls over the same period. The number of schools, colleges and educational institutions grew, with the number of girls' schools increasing from 397 in 1969 to 2.2 million in 1995; this represents an average growth rate of 10.7% per annum.

Numbers of male and female university graduates, both at home and abroad, rose from 808 in 1969 to 22,539 in 1995, with 11,596 male graduates and 10,943 female graduates. This represents an average annual growth of all graduates of 14.3% over the twenty-five years period.

4.5.1 Higher education development

Saudi Arabia has seven major universities spread over 16 campuses throughout the Kingdom, granting B.Sc., B.A., M.A., M.Sc., and PhD degrees. King Saud University (KSU) in Riyadh was the first university in the Kingdom, established in 1957. It has 19 colleges and two university hospitals: the King Khalid University Hospital and the King Abdulaziz University Hospital. It has more than 30,00

students. The Islamic University in Madinah is an international institution for Islamic studies, established in 1961. It has five colleges and grants M.A. and Ph.D. degrees. The Islamic University has 7,000 students from many countries. King Fahad University of Petroleum and Minerals (KFUPM) in Dhahran was established in 1963. It is made up of seven colleges and the Applied Research Institute. It has a student body of more than 6,000 undergraduates and 800 post-graduates. King Abdul-Aziz University (KAAU) was originally founded in 1967 as a private university, but was taken over by the state in 1971. It has ten colleges and contains the King Fahad Centre for Medical Research, the Economic Research Centre, the English Language Centre, the Computer Centre and the Centre for Technical Education. It has a student population of 28,000 male and female students. The Imam Mohammad Ibn Saud Islamic University in Riyadh was founded in 1974. It has 13 colleges and six institutes, together with 50 institutes for religious studies throughout the country and 6 institutes abroad. It grants M.A. and Ph.D. degrees and has a current student population, male and female, of approximately 20,000. King Faisal University (KFU) in Al-Ehsa in Eastern Province has six colleges and a number of training centres. There are currently approximately 7,000 students enrolled at KFU. Umm Al-Quar University UQU) was founded in Makkah in 1981 and includes eight colleges with an enrolment of more than 14,000 male and female students.

4.5.2 Technical education development

During the period 1969 to 1995 the number of students attending technical schools and institutes rose from 840 to 28,972. The number of technical schools and institutes rose from five to 91 (see Table 4.2).

Table 4.2: Technical Education

Year	1994	1990	1985	1979	1974	1969
	1414/15	1410/11	1405/06	1399/00	1394/95	1389/90
Secondary Commercial Education						
Schools/1	15	11	11	8	4	1
Enrolment	10,995	7,025	6,548	4,288	1,170	694
Graduates		1,949	1,683	1,014	338	-
Secondary Industrial Education						
Schools/1	8	8	8	8	4	1
Enrolment	8,558	7,375	3,960	1,213	2,133	18
Graduates		1,737	852	266	345	-
Secondary Agricultural Education						
Schools	2	1	1	1	-	1
Enrolment	737	408	169	322	-	128
Graduates		79	46	118	-	-
Institute of Technical Supervisors						
Schools	5	3	3	3	1	-
Enrolment	1,7380	-1,0500	346	302	444	-
Graduates		302	112	152	164	-
Summation Secondary						
Enrolment	22,028	15,858	11,023	6,125	3,747	840
Graduates	..	4,067	2,693	1,550	847	0
Higher Commercial Education						
Schools /2		2	3	4	-	-
Enrolment		374	310	264	-	-
Graduates		159	106	63	-	-

Note: 1/ schools have separate administration for morning and evening sessions.
Note: 2/ schools have been merged with the Polytechnic Colleges

... continued

Technical Education

Year	1994	1990	1985	1979	1974	1969
	1414/15	1410/11	1405/06	1399/00	1394/95	1389/90
Industrial Education						
Schools	6	7	2	2	1	-
Enrolment	7,214	3,444	266	137	105	-
Graduates		563	96	61	53	-
Summation Higher Education						
Enrolment	7,214	3,818	576	401	105	-
Graduates		722	202	124	53	-
Total Technical Education						
Total Enrolment	29,242	19,676	11,599	6,526	3,852	840
Total Graduates		4,789	2,895	1,674	900	0

Source: General Organization for Technical Education & Vocational Training

From the table above it can be seen that there has been considerable progress in the development of education, in particular the increase in the number of educational establishments. The vast increase in the number of those enrolled in the Institute of Technical Supervisors should prove to be of enormous benefit to the country's development.

4.5.3 Vocational training

From the late 1960s, the Saudi government actively encouraged vocational training (see Table 4.3). As this source tends to produce figures on a five year basis only the 1969-1999 (due 2000) were not available. However, figures for the Ministry of planning as follows published 1996.

Table 4.3: Vocational Training

Year	1994	1990	1985	1979	1974	1969
	1414	1410	1405	1399	1394	1390
Pre-Vocational Training 1/						
Number of Centres	-	-	8	6	3	..
Trainees	-	-	1,319	753	240	..
Graduates	-	-	1,175	615	194	..
Vocational Training						
Number of Centres	30	30	25	18	6	4
Trainees	6,571	6,658	4,991	3,172	1,183	578
Graduates	4,333	4,578	3,012	1,498	876	417
Vocational Training						
Trainees	2,270	2,406	4,950	4,593	..	..
Graduates	1,727	1,564	3,979	3,317	..	..
Summation						
Total Trainees	9,578	9,173	11,313	8,572	1,488	578
Total Graduates	6,101	6,201	8,194	5,466	1,135	417

Note: 1/ Combined with Vocational Training (day time) in 1407/08.
Source: General Organization for Technical Education & Vocational Training, 1996

There was an increase in the number of students receiving vocational training from 578 in 1970 to 9,653 in 1995, and a rise in the number of vocational training centres from five to 44 in the same period.

4.5.4 Special educational programmes

Approximately 60 institutes containing 6,500 male and female students have been established by the state for people with physical and mental disabilities.

4.6.1 Social care

The Deputy Ministry of Social Care (DMSC) under the Ministry of Labour and Social Affairs (MOLSA) provides rehabilitation and care for families and individuals with physical or social problems. It provides services for the disabled, juvenile delinquents and the elderly. It also seeks to maintain family relations, protect children and to emphasise the constructive role of women. By 1993 the these services were provided by DMSC through 16 orphanages, 16 social guidance and probation institutions, 5 residential nurseries for handicapped children, 2 centres for paralysed children, 21 centres for the rehabilitation of the disabled, 12 offices for vagrancy control and 9 homes for the elderly. There are also 114 Benevolent Societies providing care and services for the disabled, including 20 for women, and providing financial assistance to needy families. They offer training in appropriate skills and the organisation of cultural lectures and symposia for women, with a view to improving the status of women. These societies receive technical assistance and financial grants from MOLSA.

The number of orphans, paralysed children and disabled persons receiving at-home-care from the DMSC totalled 1,002, 875 and 217 respectively. A total of 973 elderly men and women also received care and 300 disabled men and women received vocational rehabilitation, which enabled them to become productive citizens. SR 21 million was distributed to provide at-home-care for families that look after children with special problems and subsidies provided to benevolent societies exceeded SR 51 million.

4.6.2 Social security

The Deputy Ministry for Social Security (DMSS) to provide relief assistance for temporarily handicapped persons and encouraged private benevolent societies. The amount paid under social security relief assistance rose from SR 2.3 million to SR 123.7 million by 1985 and then decreased to SR 110 million by 1999. Old age and disability pensions are provided by the DMSS. The amount paid rose from SR 39.4 million to approximately SR 1.2 billion between 1970 and 1993. In 1999 these disbursements had amounted to over 90% of the total payments made by Social Security.

4.6.3 Social insurance

In 1973 145,400 employees were covered by Social Insurance. This figure rose to nearly 5 million in 1998 when more than 90% of employees, including expatriates, were employed in the private sector. According to Al-Safe (1999) expatriates occupied 30% of hospital beds and made up 40% of out-patients clinic visitors in 1998. In response the Ministry of Health introduced a compulsory health insurance programme for non-Saudis which their employers must consider (Shabokshy, 1999).

4.7 The development of health care services

In 1926, his Majesty the late King Abdulaziz issued a decree establishing a Department of Health. The King approved its budget and charged it with the setting up of hospitals and clinics at Makkah, Madinah, Jeddah and Taif. The following year the Department was renamed the "General Directorate for Health and Aid" and was appended to the Bureau of the Attorney General. Simultaneously, a Health Council was set up in Makkah, under the presidency of the Attorney General. It included the

Director of Health, the Inspector General, the Director of Quarantine, the Commander of Makkah Police, the Director of Endowments, the Mayor of the Holy Capital, and Chairman of Ein Zubaidah Commission (Ministry of Information, 1990). Meeting once a month to study reports from different districts, the Council acts to improve standards of health, take necessary decisions to avoid epidemics and generally maintain public health, especially in the pilgrimage season. The Director of Public Health was the official responsible for the execution of council decisions and would keep the government informed of the country's health standards.

As the economy expanded it placed a further strain on the country's health services. Road building, erection of industrial premises and other buildings and the use of potentially dangerous equipment all threatened the health of workers and people living near building sites. Accidents increased dramatically; the serious ones required expert help and long-term care and pollution from development sites had a bad effect on the health of the old and very young, in particular those with weak chests, who had, also, to contend with the harsh climate.

There is no doubt that has been a rapid improvement in health care along with the economic progress in the country from 1946 onwards. By 1970 hospitals had been established in Makkah, Madinah, Jeddah, Taif, Riyadh, and Al-Hassa. The number of hospitals increased from 47 in 1970 to 176 in 1996, and the number of health centres from 519 to 1,725 in 1995. The numbers of beds in MoH hospitals increased from 7,165 in 1992 to 26,955 in 1996 when there were an additional 9,481 beds in hospitals and clinics operated by other ministries and by the private sector. Table 4.4 shows that within five years the number of MoH hospitals rose from 170 to 176 and hospitals run by other government agencies increased from 32 to 39.

Table 4.4: Hospitals and Beds in All Health Sectors 1992-1996

Year		Sectors			Total
		Ministry of Health	Other governmental agencies	Private sector	
1992	Hospitals	170	32	72	274
	Beds	26878	7285	6988	41151
1993	Hospitals	174	32	75	281
	Beds	26974	7338	7477	41789
1994	Hospitals	173	34	72	279
	Beds	26878	8357	6592	41827
1995	Hospitals	175	36	74	285
	Beds	26737	8563	6616	41916
1996	Hospitals	176	39	75	290
	Beds	26955	8794	6876	42625

Source: Annual Health Report, 1996

In order to expand and streamline its functions, the Directorate established seven health zones (districts) located in Makkah district, Jeddah, Riyadh, Madinah, Al-Hass, Assir and Tapline zones. This expansion of districts led to the conversion of the Directorate into a Ministry. This was established, in 1951, by Royal Decree No. 5/11/8697. The establishment of a Ministry signalled the beginning of a new phase of health care in the Kingdom of Saudi Arabia, with several Directorates of Health Affairs being set up in different parts of the Kingdom. Each directorate is responsible for the hospitals, clinics, equipment and technical and administrative staff under its jurisdiction (Ministry of Information, 1990, p.7).

4.7.1 Health care policy

Health care programmes emphasise both curative and preventive services (El Mallakh, 1982). The Saudi government has developed policies intended to raise the health and living standards of the people, and to ensure that all share in the growing prosperity of Saudi Arabia. Providing health care is a very complex endeavour, as it involves not only direct medical provision but also a vast number of other factors: environmental, geographical, social and political, all of which are inter-related and require technical and managerial expertise to bring about a satisfactory service which is both efficient and effective.

According to *Health for All* (Ministry of Information, n.d.), public health policy, as with other public services in Saudi Arabia, is characterised by three aims:

(a) to improve access to health services by expanding provision in order to bring health services within reach of the entire population, regardless of whether they live in urban, suburban, rural or desert areas;

(b) to broaden the range of health services available, for example, fertility treatment departments were introduced in a number of hospitals during the 1990s;

(c) to improve the quality of service provision.

This policy emanates from the Saudi government's concept of the health issue. Health is a basic necessity of life, like air and water, and is therefore an inalienable right of the Saudi citizen, which their ruler should provide as an integral part of the comprehensive development policy. Thus the principle of 'health for everyone' is the best phrase that sums up health policy of Saudi Arabia; for it takes into account the legal right of every citizen to suitable health care of a good standard.

The health of each individual in society is important for its economic development. Improvements in public health services enable the citizen with good health to be able to contribute more effectively to the development of society and improve living conditions, and consequently, face the challenges imposed by rapid economic and technical advances worldwide.

Therefore, health service system throughout the country now covers all the essential elements of primary health care with the addition of mental health and dental health activities to be included in the primary health care setting. This health infrastructure reaches all regions and villages (Ministry of Health Annual Report, 1996).

> "The Ministry of Health policy denotes that organised professional services, through health centres should be available to every citizen within an hour of most common mode of transport available in that area", Al-Mazrou, (1990:22).

This aim was largely achieved by 1996. Where possible health care services were made accessible to all population within easy reach of at most one-hour travel. These health centres were adequately equipped in both rural and urban areas. A health centre in a rural area may serve a population of 500-3000, and in an urban area a population of 5,000-10,000. A major health care centre serves a group of between five and ten small health care centres, and it may be equipped with ancillary investigation facilities, such as laboratory, x-ray and epidemiological facilities, dental clinics and emergency care. A group of such centres are then linked with a 30-50 bed rural hospital, which in turn is linked with sub-regional hospitals, with a bed capacity of 100-300 depending on the population. For below 50,000 population 100-150 beds, for above 50,000, 200-300 beds (Ministry of Health, 1996). These hospitals are to be linked with tertiary services in each region.

4.7.2 Health care agencies

Health care services can be classified as follows:

First Level:	Primary Health Centres
Second Level:	General Care Hospitals
Third Level:	Specialised Hospitals

Private sector health care organisations developed to create a private health care sector (Stacey International, 1990). Public sector health care organisations developed under the aegis of government agencies, such as the Ministry of Health, Saudi Arabian National Guard Health Affairs (SANG), the Ministry of Defence and Aviation (MODA), Armed Forces Medical Services (AFMS), Ministry of Interior Medical Services, Security Forces Hospital, King Faisal Specialist Hospital & Research Centre (KFSH), and Universities Hospitals, as well as the private health sector. Most of the government agencies hospitals are large with large number of manpower increases (see Table 4.4), and possess not only sophisticated facilities, but also are leading institutions for training of medical specialists in all major and minor sub-specialities.

Between 1975-1996, that is from the end of the First Five Year Development Plan to the start of the Sixth Five Year Development Plan, the Ministry of Health increased the number of hospitals from 47 to 175, with the number of beds increased from 7,165 to 26,737 beds (Table 4.4). The number of clinics increased over the same period from 519 to 1725. By 1980 there were 87 well-equipped modern hospitals with almost 14,000 beds belonging to the Ministry of Health and the private sector alone. Over the next five years the number of hospitals increased to 157, which, by

1986, were providing the country with an estimated total 29,000 beds (Ministry of Planning, 1996). The Ministry of Health was responsible for 86 of these hospitals while, together, the private sector, the Ministry of Defence, the National Guard, the Higher Education Ministry and other governmental agencies supplied the remainder (Stacey International, 1990).

By 1996 there were 290 hospitals with 42,625 beds. The Ministry of Health ran more than 176 hospitals directly with 26,737 beds (see Table 4.4). The Ministry also supervised private hospitals, of which there were more than 75 (The Achievement of Development Plans, 1996).

As for the private sector, the number of hospitals increased from 72 with a 6,988 bed-capacity in 1992, to 75 private hospitals with a total bed capacity of 6,876 by 1996. In addition, there were more than 598 private dispensaries centred in Riyadh has 191, Jeddah has 108, Al-Sharqiah 53, Assir 29, Taif 34, Makkah 28 and Madinah has 22. These had more than 3,000 physicians employed in them. Most of the hospitals were located more in large cities. The private hospitals arranged visits by senior professors of medicine for consultations. The total number of private clinics in 1996 stood at 768 and 598 dispensaries (Ministry of Health, 1996).

Recent statistics have shown the National Centre for organ transplants to be prominent in the field, having carried out following transplants: 471 kidney, 64 cornea, 49 heart, 23 liver, 3 lung and 4 pancreas, with an 80% success rate.

Table 4.5: MoH Health Medical Manpower (1970-1996)

Year	*Allied personnel	Nursing	Physicians	Total
1390 (1970)	1,396	2,253	789	4,438
1394 (1974)	2,670	4,234	1,900	8,804
1399 (1979)	4,090	6,166	3,408	13,664
1405 (1985)	10,086	20,707	9,257	40,050
1410 (1990)	15,329	29,124	12,959	57,412
1414 (1994)	19,325	35,687	15,125	70,137
1415 (1995)	19,973	15,476	15,576	33,025

Source: *The Achievement of Development Plans*, 1996. * Ancillary staff

Table 4.5 shows a phenomenal rise in the number of medical staff in all the above categories. However, the number of nurses has fluctuated dramatically. The source of this information gave no detailed explanation for the vast difference between the 1979 and 1985 figures and between 1994 and 1995 figures. This information would have been of value.

Table 4.6: MoH and other Government Agencies Medical Manpower

Allied Health personnel			Nursing Staff			Physicians			
Total	Other agency	Ministry of Health	Total	Other agency	Ministry of Health	Total	Other agency	Ministry of Health	Year
1,741	345	1,396	3,261	1,008	2,253	1,172	383	789	1970
3,215	545	2,670	5,857	1,623	4,234	2,641	741	1,900	1974
5,597	1,507	4,090	9,791	3,625	6,166	5,184	1,776	3,408	1979
13,790	5,827	7,963	27,812	12,893	14,919	13,893	6,403	7,490	1984
25,192	10,067	15,125	45,840	17,574	28,266	22,633	10,016	12,617	1989
32,167	12,842	19,325	61,246	25,559	35,687	29,227	14,102	15,125	1994

Source: *The Achievement of Development Plans*, 1996.

Table 4.5 shows that when comparing MoH and other Government agencies medical management there has been a continuous rise in the number of personnel. Unfortunately, when comparing Table 4.5 with Table 4.6, we do not have comparable figures for 1995.

Table 4.7: MoH Hospital's Personnel, Physician, Nurses, Pharmacists and Allied Health Personnel, by Nationality

Category	Nationality	Year				
		1992	1993	1994	1995	1996
Physicians*	Saudi	1611	1790	2113	2403	2606
	Non Saudi	12289	12764	13012	13073	12660
	Total	13900	14554	15125	15476	15266
Nurses	Saudi	4631	5273	6489	6879	7705
	Non Saudi	27598	28100	29198	28340	27242
	Total	32229	33373	35687	35219	34947
Pharmacists	Saudi	230	261	363	423	469
	Non Saudi	388	399	617	511	447
	Total	618	660	980	934	916
Allied Health Personnel	Saudi	6993	7875	8487	9185	9804
	Non Saudi	9584	9993	9858	9854	9530
	Total	16577	17868	18345	19039	19334

*Include Dentists

Source, Annual Health Report, (1996)

Table 4.7 shows that Saudi physicians (including dentists) increased by 62% within four years from 1611 to 2606, whereas non-Saudis in the same category only increased by only 5% from 12,289 to 12,660. Saudi nurses showed a 60% rise from 4631 to 7705, but non-Saudis actually dropped by <2%. Pharmacists showed a gain for Saudis of over 100%, whereas non-Saudis showed only a 15% gain. Allied health personnel, however, showed a slight drop (c.0.5%). The same slight drop was shown for non-Saudis. Therefore it can be assumed that the Saudi-ization programme is effective for qualified medics and nurses but less so for the lower occupational category.

4.7.3 Problems of health care

As has been detailed above, health care services have been expanded rapidly in recent years. This expansion has encompassed all sectors of the health service due to the manifold increase in the Ministry's health budget allocations since 1991. As well as the increase in the number of hospitals and their beds (see Table 4.4), there was a corresponding increase in the number of clinics, health posts, pharmacists and medical manpower (see Tables 4.5 and 4.6). This meant that the health sector expanded in the number of skilled personnel including nationalities other than Saudi (see Tables 4.7) in all spheres, and emphasis, according to the Ministry of Health, was placed on quality as well as quantity. Table 4.8 refers to private organisations co-operating with the MoH public hospitals on a contract basis, and Table 4.9 shows manpower in the private sector by Saudi nationalities and expatriots.

Table 4.8: Manpower in Health Private Sector by Nationality

Nationality	Physician	Nurses	Allied	Technical	Management	Labour
Saudi	121	16	51	46	978	332
Expatriate	7,178	9,967	3,826	1,278	2,649	6,872
Total	7,299	9,983	3,877	1,324	3,627	7,204
% Saudis	1.7	0.2	1.3	3.5	27.0	4.6

Source: MOH/KSA Annual Report (1995)

In the private sector the Saudi physicians are poorly represented, comprising less than 2% of the total employed. The situation with nurses is even worse: only 0.2%. It is only in the management sector that proportionally more are employed: 27% of the total. It is clear from these figures that in the private sector all the occupational categories listed show a predominance of non-Saudis.

Table 4.9: Manpower in Contracted Companies in MoH Hospitals, by nationality

Nationality	Physicians	Nurses	Allied Personnel	Technical	Administrative	Worker
Saudi	73	153	192	184	325	2,565
Non-Saudi	2,907	7,252	3,208	2,871	2,074	2,1691
Total	2,980	7,405	3,400	3,055	2,399	24,256
(%)	2.5	2.1	5.6	6.0	13.6	10.6

Source: MOH/KASA *Annual Report* (1995)

From the figures displayed, contracted companies in MoH hospitals principally employ non-Saudis.

The rapid progress in the field of public health has been characterised by a growing awareness of the need for achieving three factors (*Achievement of Development Plan*, 1996)

1. Concentration on the development of technical manpower in this sector, which more than any other suffered from shortage of trained personnel;

2. Placing simultaneous emphasis on protective and curative medicine;

3. Completion of the necessary studies to draw up a comprehensive health programme to decrease the mortality rate and prevent the spread of diseases in the Kingdom (Ministry of Information, *Plan of Social and Economic Development*, n.d.).

The achievement of these wide-ranging objectives, however, has been faced with many obstacles, despite large expenditures, and has suffered from the lack of sufficient staff, adequately trained in their respective roles (such as nursing, surgery, administration), which meant that there could be no expansion in health care services. To remedy the shortage, the Ministry of Health prepared a large-scale programme for training its staff at all levels.

Without adequate planning, and programmes for the long-term development of health services, progress could, at best, be only piecemeal. The Ministry of Health has addressed this issue so that health services could develop smoothly within the framework of, and in harmony with, the overall development of Saudi society.

4.7.4 Plans and programmes of health organisations

An historical legacy of health care development in Saudi Arabia is that health services are overseen and delivered by (or on behalf of) several organisations:

1) The Red Crescent Society, which takes care of emergency cases (see Table 4.10).

2) Military Health, which provides health services to personnel and families of the Armed Forces, and belongs to the Ministry of Defence.

3) National Guard Medical Services. Upon Prince Abdullah Bin Abdulaziz taking command of the National Guard in 1962, the National Guard Medical Services began to develop a wide range of ambitious plans. These plans covered all the National Guard's facilities and are today considered the basis on which achievements have been realised.

Although there is a danger both of competition between agencies and the wasteful duplication of services, these organisations work co-operatively in transferring ill patients between hospitals without charge and in delivering training programmes. They all also co-operate with other health care providers, each with their own apparatus, staff and budgets.

In the cities, especially Riyadh and Jeddah, Madinah and those of the Western Province, the number of road accidents forms 81% of the total. Clearly something needs to be done to curtail this number in the interests of both the people and the Health Service in general. Sunstroke victims are more numerous in the Western and Northern Provinces, which suggests a need to address the problem.

Table 4.10: Saudi Red Crescent Society: cases offered First Aid and carried by ambulance to hospital: 1996

Region	Sun Stroke	Road Accidents
Riyadh	10	2542
Jeddah	14	3675
Western Prov.*	162	3680
Madinah	6	1629
Eastern Prov.	14	875
Qaseem	2	459
Southern Prov.**	9	620
Hail	0	136
Northern Prov.***	157	334
Tabuk	2	349
Total	376	14299

Source: Saudi Red Crescent Society.
Note: Statistics excluding the services of the society during hajj time.
*Including Makkah, Taif, Al Baha.
**Including Aseer, Jizan, Najran.
***Including Iraqi Refugees Centre.

Overall, the Saudi government has attempted to balance the desire for a rapid expansion of health service provision with a desire for co-ordinated policy. This has involved, initially, recruiting an overwhelmingly expatriate workforce, and recently developing policies for the Saudisation of the workforce involving training programmes so that Saudi people can do the jobs that were initially carried out by expatriate doctors, nurses and technicians).

4.7.5 Health service provision for pilgrims

The Saudi government, in particular the Ministry of Health, along with the private sector, has had to concern itself with the health care of more than just Saudi citizens and foreign workers. The holy cities of Makkah and Madinah are situated within the

Kingdom (see Figure 3.1), and are places of pilgrimage. Pilgrimage is undertaken not only by the faithful of Saudi Arabia, but, also by Muslims from around the world. Unfortunately, these pilgrims are not always fit and healthy. The harsh Saudi climate, with its high temperatures and windblown sand, can easily lead frail pilgrims to suffer heat exhaustion and respiratory problems (see Table 4.11).

Table 4.11: Incidence rate (per 1000 pilgrims) of sun stroke and heat exhaustion, 1987-1996

Year	Arafat day	Total of pilgrims	Sun stroke		Heat exhaustion	
			No.	%	No.	%
1987	3 Aug	1619324	710	4.4	5980	36.9
1988	21 July	1379556	297	2.2	4447	32.2
1989	12 July	1466995	1076	7.3	7000	47.7
1990	1 July	1644470	197	1.2	4689	30.3
1991	21 Jun	1628186	562	3.5	5241	32.2
1992	10 Jun	2178141	1174	5.4	7308	33.6
1993	30 May	2035375	783	3.8	6810	33.5
1994	18 May	1533506	905	5.9	9675	63.1
1995	8 May	1537168	152	1.0	5063	32.9
1996	27 April	1609423	226	1.4	3093	19.2

Source: Annual Health Report (1996)

Furthermore, the close proximity of so many pilgrims can exacerbate the transmission of communicable diseases. Adequate health provision for the pilgrims is therefore essential. Permanent hospitals and clinics have been established in response, supplemented with temporary facilities during the ten days of the Hajj. Some health staff are specifically designated to the pilgrims.

The huge number of pilgrims suffering from sunstroke and heat exhaustion reveals the problem facing the Health Service and the need to provide information regarding

preventative measures. By 1996, however, the figures revealed a drop in the stated illnesses; though in the case of heat exhaustion the numbers were still high.

4.8 Management of hospitals: contracted-out management

Due to the rapid speed of progress and development in the Kingdom, and the shortage of skilled labour in both government and private sectors, most hospitals, initially, had to be managed and operated by being contracted out to foreign health companies. Contracting out management has been used in management of: MODA for all of its hospitals; MOI for its 485-bed hospital in Riyadh; some of the MOH hospitals; King Khalid Eye Specialist; SANG for its two 500-bed hospitals and some university hospitals (Al-Amri, 1995).

The policy of contracting out has been embodied in the Five Year Development Plans, which are examined below.

4.8.1 Third Five Year Development Plan

The growth of private sector participation in the provision of health services during the Third Five Year Development plan (1980-1985) made the private sector a critical part of the health services network of the Kingdom. This Development Plan went further than the previous Plans, which aimed to increase the involvement of the private sector. Now the Ministry saw the need to co-ordinate the various health services, to strengthen regulations concerning private health services, and regular reviews of private sector fees on the basis of market prices and the quality of services provided.

This was a very ambitious plan as it required managerial skills of a high order and, further, required the import of more foreign labour, which was contrary to the desired Saudisation of the country's work force.

The growth of the private sector during the period of the Third Five Year Development Plan (1980-1985) made the private sector a critical part of the health services network of the Kingdom. Its scope of participation in the health care field was expanded in the Fourth Five Year Development Plan (1985-1990). The development of private sector services involved co-operation and co-ordination with other agencies planning health services, increased evaluation of private health facilities and the strengthening of regulations concerning private health services. This co-ordination of effort required a regular review of private sector fees on the basis of market prices and the quality of services provided (Ministry of Planning, 1990).

4.8.2 Fourth Five Year Development Plan

Among the objectives for the Ministry of Health outlined in the Fourth Five Year Development Plan (1985-1990) was the encouragement of private sector participation in the health services by the provision of loans, technical and financial subsidies were also emphasised. It considered the participation of the private sector in the field of health care as an important support to the services of the government and an extension of the formal health care system. Among the facilities provided by the government, in restoring private health care facilities, were land and loans on easy terms, equal to half the total costs of the project.

The Ministry of Health also provided supervision by establishing organisational regulations and executive controls. Among these regulations were price controls on each type of service provided by the private sector.

Thus the main objectives for the health sector are: to continue to strengthen primary health care, to increase co-ordination between the ministry of health and other sectors of health agencies in providing health services, to further develop the health service manpower, the emergency medical services with special attention to the requirements of the Hajj season, and expand exchange of expertise between the kingdom and international health organisations, also to continue encouraging the expansion of the private health care programs and promote private sector participation in all health sector services and the operation of all health sector facilities (The Fourth Five Year Development Plan (1985-1990: p329). This encourages the government sector to co-ordinate, on a contractual basis, the requirements of the health service with the professional capacities already available in the private health sector, and to provide manpower and equipment.

The Saudisation target in the Fourth Development Plan, one of the most important aims of the plan, was a reduction by 22.6% in the number of non-Saudi workers from 2.66 to 2.06 million from the non-oil sector, (ibid: p50).

4.8.3 Fifth Five Year Development Plan

The objective of reducing government involvement in economic activities, that can be efficiently and profitably performed by the private sector, was further emphasised in the Fifth Five Year Development Plan (1990-1995). Public or private sector ownership and management control for many enterprises should be determined on the basis of which sector is more likely to produce a higher level of efficiency and

innovation, and, therefore, be of greater economic benefit to the Kingdom. Experience in other parts of the world at that time, for instance USA, Japan and Western Europe, demonstrated that the private enterprise, operating in a competitive environment, is usually more likely to meet goals of economic efficiency and growth (Hemming and Mawson, in Al-Omais, 1988).

Strategic objectives for the Fifth Five Year Development Plan (1990-1995) aimed, through its policies, to increase private sector participation in socio-economic development. The operation and management of facilities by the private sector again represented a key element in this strategy which aimed at greater health service efficiency and higher staff performance levels. To do this it was considered necessary to establish appropriate quality controls at health facilities; monitoring of health care standards and licensing requirements and integration of private sector health services with the referral system of the Kingdom in each region. (Ministry of Planning, 1995, pp.146-147).

This Fifth Five Year Development Plan, therefore, sought to strengthen and continue the resolve of the Fourth Plan and continued the increase in private sector investment in the economy so as, it was hoped, that economic efficiency, innovation and competition would be increased. In this way subsidies would be reduced and there would be a wider distribution of ownership of enterprises. To increase private sector participation in the economy various measures would be instigated as follows: the number of leading businessmen on the governing boards of government-owned enterprises would need to be increased; selected government enterprises would need to be sold to the private sector and shares in selected government enterprises would need to be sold to private investors; the private sector would have to be encouraged to compete with certain government monopolies; contracting with private businesses

would be necessary for services provided by the government, where possible; the private sector would need to be encouraged to offer new services in sectors such as public health services, that traditionally have been provided by the government; projects would need to be identified that can be undertaken through lease-purchase or build-and-operate agreements with the private sector (Ministry of Planning, 1995, pp.146-147).

Here one sees that the situation is becoming more complex. Not only is privatisation to be increased but also competition between government and private sectors for services is to be encouraged and aspects of Western capitalist systems such as share issues and lease purchase are to be introduced.

4.8.4 Sixth Five Year Development Plan

The Sixth Five Year Development Plan (1995-2000) was concerned with the development of the private sector by every possible means. Therefore, the government intended to hand over responsibility for buying medicines, establishing hospitals and clinics, and to contract out services to create competition with the private sector. This was to help to complete the infrastructure of the country, as the Sixth Development Plan (1995-2000) was prepared with a long-term view of national economic development. Long-term economic forecasts for the next twenty years suggest positive growth for oil sector and expanding potential for the development of the non-oil sectors. Such forecasts are supported by the private sector's steadily expanding role in the development process and by continuous efficiency improvements in investment activities, production techniques and organisational management re-engineering structures. Furthermore, there is now private sector investment through the gradual introduction of privatisation programmes and the

planned development of the domestic financial markets. The new initiatives and investment incentives will provide an encouraging climate for the repatriation of Saudi private capital and its investment inside the Kingdom. There are positive indicators of this optimistic perspective of the Saudi management efficiency. For instance, Saudi ARAMCO is providing a major role, not only in the development of oil production capacities, but also in transferring high technology, and training and developing human resources.

The Kingdom's Five Year Development Plans emphasised the need for the development of private sector activities, not only in health services and government services, but also to cultivate self-reliance through defined functional responsibilities for both government and private sectors. The private sector, it believes, motivates individuals to accept responsibility for their own organisation, the government sector on its part supporting the individuals by providing essential environmental protection, relevant skills and access to primary health care. Hence the private sector responsibility and government support are complimentary to each other, neither can be fully effective without the other. In other words, it is not possible to achieve the government's objective of improvement without the effective implementation of all management elements, and the same applies to the private sector.

The Saudi government continued in its policy of encouraging the private sector to participate in providing health services. The Sixth Five Year Development Plan (1995-2000) mentions the following steps which have been taken by the Saudi government in support of greater private sector participation in the development process by: Providing interest-free long term loans for the construction and operation of hospitals and clinics, and pertinent support services; providing opportunities to contractors for constructing and preparing government health facilities through direct

finance from the state budget; providing opportunities to contractors for the maintenance and cleaning of all health facilities, and the full operation of some hospitals and supporting the manufacture and marketing of drugs and medicines (Ministry of Planning, 1995, :310).

In providing interest-free loans the government was acting on Islamic principles, which forbid charging interest. Due to the foreseeable need to attract more contractors from the private sector to work in the health service, financial aid from the government was to be given directly to the contractors. The need to have home-produced supplies of drugs and medicines, so as to maintain regular and immediate supplies, meant that manufacture and marketing were to be encouraged in Saudi Arabia.

The Sixth Five Year Development Plan (1996-2000) also included projects which would give the private sector the opportunity to finance the construction of many health facilities. These included: constructing primary health care centres and intermediate health colleges; establishing health institutions and training centres for emergency medical services (Ministry of Planning, 1995, pp.310-311).

With the rapidly expanding population (see Tables 3.4 and 3.5) the Government found it necessary to not only increase the involvement of the private sector but also to provide health care facilities and training centres to meet the population's needs.

The strategy of the Ministry of Health (1995) has been:

1. "Prevention is better than cure" this adage has been implemented in the great number of Primary Health Care Clinics in the Kingdom as a basic means of

maintaining the health of the community and the prevention of disease and epidemics;

2. Providing free and equal medical attention to Saudi nationals as well as foreign residents;

3. Eradicating diseases and preventing the spread of contagion and epidemics either by continuous hygiene control or by preventive measures and the co-ordination of relevant programmes;

4. Educating citizens and residents in hygiene and fostering this culture especially in the field of motherhood and childcare, thereby raising the standard of health in the country;

5. Co-ordinating preventive health care with remedial services in order to provide all people with the best health care;

6. Developing and continually upgrading health institutions and providing them with the very best in human and technical resources;

7. Expanding the network of health care services to cover all corners of the Kingdom;

8. Upgrading the scientific and technical standards of all employees of the various health institutions and the recruitment of highly proficient staff to man them;

9. Providing all health institutions with a highly qualified staff of Saudi doctors, technicians and administrators in order to achieve self-sufficiency;

10. Co-ordinating the efforts of the Ministry of Health and the health sectors of other ministries and governmental bodies in order to achieve development in a unified framework;

11. Encouraging the private sector to participate in the health services, supporting and providing the participants with loans and technical and financial subsidies under the supervision of the Ministry of Health, and encourage Saudis and non-Saudis or their contractors to take out some health insurance;

12. Supervising pharmacies and overseeing the classification and approval of proper medication and pricing.

The outcome of these aims have been largely successful, and have contributed to the regulation of health care in the Kingdom and have inspired participants continually to reach out toward higher goals and achievements.

4.9 Regulation and control of the private health sector

The Saudi Ministry of Health supervises the private sector's health projects including hospitals, dispensaries, clinics and trade in medicines and pharmacies in several ways. As well as determining the proper price for each type of service provided by the private sector and for medication, the Ministry of Health also sets terms for licenses granted for the medical practices in different fields, with Health Affairs Directorates constantly monitoring commitment to the terms. It also monitors imported medicines, their validity and availability in the markets, especially basic medicines and their sale at fixed prices.

Another of the Ministry's tasks is to monitor, control and technically inspect private institutions in order to encourage good performance and create honest competition

between such institutions. Penalties have been initiated for violations of regulations if committed. The Ministry is also responsible for determining terms, laws and regulations for the employment of technical cadres in such institutions and issuing work licences for personnel who meet required conditions. It investigates complaints received from citizens against any institution and takes the appropriate action in light of investigation results. The Ministry of Health records pharmaceutical companies and their products in keeping with the controls of pharmacology regulations and its executive by-laws and monitors anaesthetic and dangerous medication as well as medicines that are barred from circulation or sale except under the pharmacology and poisons regulations and investigates violations committed against the pharmacology and poisons regulations and takes the necessary measures in this respect (Ministry of Information, *Health For All*, 1990, pp.99-100).

The growth of the private sector during the period of the Third Five Year Development Plan (1980-1985) made the private sector a critical part of the health services network of the Kingdom. Its scope of participation in the health care field was expanded in the Fourth Five Year Development Plan (1985-1990). The development of private sector services involved co-operation and co-ordination with other agencies planning health services, increased evaluation of private health facilities and the strengthening of regulations concerning private health services. This co-ordination of effort required a regular review of private sector fees on the basis of market prices and the quality of services provided (Ministry of Planning, 1990).

By the Fifth Five Year Development Plan the private sector was being encouraged to compete with the public sector in offering new services, including public health services, that had traditionally been provided by the government. The Sixth Five Year Development Plan had expanded this aim to develop the private sector by every

means available. New initiative and investment incentives encouraged greater private sector participation in the development process.

4.10 Summary and conclusion

The birth of a state involves the concomitant birth of its public administration. The development of Saudi public administration was slight at first, the state being of relatively little geopolitical importance. Exploitation of its oil resources changed all that. As oil started to flow out, so revenues started to flow in. Economic and social development became possible, and Saudi Arabia developed a commercial and industrial infrastructure. The relative absence both of labour and of expertise (in most fields) demanded the use of expatriate workers from both the West and from Asia. These people brought with them their health care and social needs.

The first health care services in Saudi Arabia came into existence soon after the birth of the new state. With the escalation of oil revenues, more health services became feasible. However, additional to Saudi citizens requiring health care, the vast army of non-Saudi workers and their families and the huge influx of pilgrims visiting the holy cities of Makkah and Madinah, also required health care. The extent to which demand led supply or vice versa is not clear. Costs, however, rose faster than oil revenues, and the government set about rationalising health care by encouraging first, foreign firms to take out health insurance for their workers and then gradually began to encourage its own citizens to do the same.

Soon it became obvious that the National Health Care Service was unable to satisfy the needs of all its citizens. Certainly, the rich could go abroad and purchase private health care, but this was available for only a small number of people; for not only was possession of adequate funds necessary, but emergency treatment was needed on

the spot. This provided the incentive for the government to encourage the private sector to build and staff hospitals and clinics (see Table 4.5) and to bring in staff, initially from abroad, to supply them.

In spite of the vast wealth generated by oil sales, the government became aware that it was prudent to curtail or reduce the amount of money draining from the public exchequer into the rapidly expanding health service. By 1996 not only had the principal cities in the kingdom several large hospitals, but smaller hospitals and clinics were established within reach, by road or air, of all settlements.

When a country does not have hospitals and clinics, questions about how to administer a health service are theoretical. Issues about how to build, equip and staff hospitals take centre stage. Now that Saudi Arabia has its hospital and health care infrastructure, questions about their administration have become more important in a practical sense. Issues about the administration of healthcare have to be considered:

1. Who should run the hospital - a medical practitioner or a trained manager?

2. The way forward to contract-out all hospital management services?

3. Should existing hospitals with contracted-out management be replaced by in-house management?

During the 1980s 'a major preoccupation of governments of a diversity of political persuasions, and in countries of a wide range of stages of development, has been the role of the state in the economy' (Fraser and Robert, 1988, p. ix).

The privatisation of health services is having profound effects on health care delivery in Saudi Arabia. Although privatisation is a policy being enacted nationally (and

internationally), its effects are uneven and highly localised. It involves the simultaneous expansion of services in some communities and withdrawal of services and investment from others, as health care providers seek out new and profitable market areas. These issues will be examined in Chapters 6 and 7.

Looking more broadly at economic development, Saudi Arabia is in the reverse situation to the usual predicament of developing countries where there are many people and little money invested for development, as it has 'untold oil wealth, but few people' (Hickson & Pugh, 1995: 208). The latter has presented, and still presents, problems for the government. In order to speed up development and provide for the needs of a 'modern' society the government brought in expatriate workers, some of whom possessed expertise in the required skills, and others, particularly unskilled men from Asia, who were prepared to undertake menial work that Saudi men were disinclined to do (Al-Mashouq *et al*, 1996; Al-Nughimshi, 1997).

At first, the majority of medical and ancillary staff were non-Saudis. However, through initiating a series of Five Year Development Plans, the government introduced training schemes to establish a skilled workforce of its own people who, ultimately, would take over the running of the country's health management, education, social and economic need services. This has been a slow process as health training for medical staff had, initially, to be undertaken abroad for a number of years.

Saudi Arabia has a public health care system that caters for all, with excellent access for most of its population, and specialist facilities of world class standard. The whole system is administered in a piecemeal fashion by a range of agencies. A succession of Five Year Development Plans has brought about both the massive expansion of

health service facilities and a number of administrative tensions. Three key inter-related tensions concerning how hospitals should be managed: by medical staff or by managers/administrators; by Saudi nationals or by expatriates; by an in-house management team or by a contracted-out management team. Much of the rest of this study is concerned with attempting to identify resolutions to these tensions.

Chapter Five

Research Methodology

5.0 Introduction

This chapter defines the methodology for the fieldwork undertaken to carry out this study. The chapter considers how the data was collected, along with an appreciation of the advantages and disadvantages of various data collection techniques. The chapter describes how the selection of the participants was carried out, how the pilot study was undertaken, and how the interviews were carried out and the questionnaires were designed and distributed.

Many research methods have been developed for collecting the data applicable for the subject under examination, but some methods are likely to be more effective than others regarding the issue under study (Al-Sabban, 1990; Al-Alawnah, 1996). Research methods are employed for the purpose of discovering new knowledge, to ensure validity in the search for this knowledge, to order this knowledge meaningfully, and to test existing propositions (Shalaby, 1980; Al-Alawnah, 1996).

Primary data for this research was obtained from respondents to personal interviews and from written responses to questionnaires. The reason for gathering primary data was the relative dearth of previous research into this area. The reason for using these methods of collecting data was that these methods have been shown to be effective in gathering primary data.

5.1 Interviews

As a research technique, an interview has been defined as one to one situation or a small group consisting of two to three persons link conversation initiated by the interviewer for the specific purpose of obtaining research-relevant information, and focused on content specified by research objectives of systematic description, prediction, or explanation' (Cohen and Manion, 1994:271). Weiss (1994) comments that the interview has become a foremost method for rich data to be collected. The value of interviewing is that the person being interviewed can describe the situation much more deeply (than, say, in response to a questionnaire), can communicate their feelings, and can identify with their own or others response to the situation. Another advantage of the interview technique is that respondents' confusion can be detected and clarified accordingly, Moreover, questions can be reworded so as to elicit meaningful answers (Al-Alawnah, 1996). The interview as a data collection technique offers an opportunity of interaction between the interviewer and the respondent whereby it is possible for the respondent to ask for clarifications of vague questions and for the interviewer to clear up obscurities and ask for further information. Furthermore, Banister *et al.* (1994) argue that conducting interviews can permit explanation of issues that may be too complex to investigate through quantitative means. Therefore the views of the participants cannot be readily represented within the form of questionnaire.

However, there are several different types of interview. In a structured interview, a previously determined set of questions is put to the interviewee. A semi-structured interview consists of both closed (yes/no-type) questions and open-ended questions. These latter questions are usually not prepared but they are created on the spot as the

interview develops and as the situation demands. There is an opportunity in this type of interview to comment further. In the open-ended interview, the interviewer does not prepare questions in advance. Rather the interview proceeds informally and progresses according to the specific aims of the interviewer. The interviewee is able to comment on situations and give his/her own opinions as the interview is conducted in conversational style (McKernan, 1991; Hopkins, 1993).

When deciding to interview as many of the relevant people as possible, consideration had to be given as to what type of interview would produce the required data. Different kinds of interviews have been outlined and contrasted above such as structured, semi-structured and unstructured interviews all their advantages and disadvantages. However, the nature of the area investigated and the objectives of the interviewer are considered as determinant factors in choosing the type of interview. The type of interview selected for this study will be outlined after examining the differences between the above three kinds of interviews. Distinctions between these types of interview lies in the nature of the questions asked, the degree of control over the interview exercised by the interviewer, the numbers of people involved (Hitchcock and Hughes, 1995).

5.1.1 Structured Interviews

The advantages of using structured interviews are the following:

1-Constructed schedule made of fixed alternative items

2- Can be easily categorised

3- Can be easily coded

4- Can be easily analysed (Cohen and Manion, 1994).

In a structured interview, the interviewer attends the interview equipped with a prearranged, sequenced and carefully worded list of questions. These questions are characterised by being short, direct and capable of eliciting immediate responses. These characteristics reveal that this type of interviews bears some resemblance to questionnaires in that the schedule of questions is fairly rigid. The same questionnaire is presented in the same manner and order to each subject and the choice of alternative answer is restricted to a predetermined list, Dalen (1972). Another shortcoming is that not always possible to specify in advance what questions are appropriate or even important (Hichcock and Hughes, (1995).

5.1.2 Unstructured Interviews

Unstructured interviews on the other hand, attempt to provide a record of the free flow of deeper and meaningful information from those being interviewed in an open situation. Unstructured interviews are useful when little is known about the area of study (Holloway, 1997). Unstructured interviews are concerned to elicit subjective information by exploring issues that seem to be too complex to investigate by administering a structured ordered list of questions. The interviewer, while appearing to conduct a conversation, "guides and bends it to the service of his research interest" (Hichcock and Hughes, 1995: 163).

5.1.3 Semi-structured interviews

In the present study, a semi-structured interview technique was employed. The basic characteristic of semi-structured is that it is a hybrid of the structured and the unstructured interviews. This is itself qualifies to be an advantage because it combines the advantages of both types of interview. As Banister *et al.* (1994) pointed out, this type of interview has the advantage that it is possible to tailor the questions

to the position and comments of the interviewees. That is what is considered to be very important as it is desired by the researcher to achieve more than ready responses to set questions and to build up a rapport with interviewees. It is expected that the wording and the sequence of the prepared questions will be changed in order to obtain greater elicitation of the subject in question. This type of interview is not without shortcomings as mentioned earlier (see Table 5.1). For example, the presence of the interviewer can affect the responses obtained, so that sometimes respondents give biased answers to please the interviewer.

Table 5.1: Advantages and disadvantages of interviews

Advantages	Disadvantages
Allows greater flexibility in the questioning process than questionnaires.	The cost of interview studies is significantly higher than the cost of the questionnaire.
Allows grater control over the interview than questionnaires.	The interview is highly vulnerable to the bias of the interviewer.
Usually the personal interview results in a higher response rate than questionnaires.	The interview lacks anonymity, which the questionnaire typically provides.
The interviewer can gather supplementary information about the subject	The interviewee may provide answers which he/she believes will please the interviewer.
The interviewer is in direct contact with the respondent	The interviewer may not be eager to answer questions due to fear that his answers may be considered an attack on the management's policies.

Source: adapted from (Mckernan, 1991; Hopkins, 1993; Cohen and Manion, 1994; Weiss,1994)

Therefore, the following precautions suggested by Al-Sabbab (1990), were taken by the author of this thesis before conducting the interviews:

1. Preparation was made in advance of reading as much as possible about the interview questions intended to ask;

2. Preparation was made beforehand for all the questions related to the objectives of the study, which were to be adhered to in each interview;

3. The objective of the task was discussed with as many different experienced researchers as possible and in different institutions; and

4. The informants were carefully chosen in terms of special experience, knowledge, status and willingness to participate and share their knowledge.

5.1.4 Advantages and disadvantages of interviews

However, there are advantages as well as disadvantages which must be addressed as far as possible when employing the interview technique as shown above in Table 5.1

5.1.5 Interview design

According to Mason (1996: 35-47), the ideal interview participant is the informant who meets the criteria of being an individual with special knowledge, communicative skills, status, and willingness to contribute to the present research. Other researchers, such as Al-Sabbab (1990), emphasise that the importance of participants' accessibility is a criterion to be taken into consideration, and that this is a privilege that cannot be overlooked in this world of extremely busy and time-conscious professionals. The selection of relevant interviewees provides the researcher with reliable and valuable data. The success of the interviews depend on the desires, time, comfort and co-operation of participants (Al-Sabbab, 1990:192).

With the above-mentioned criteria in mind, the researcher decided to select participants who meet the following criteria:

1. Willingness to participate and communicate their knowledge as specialist informants in the subject under investigation;
2. Time availability;
3. Experience either in supervising positions;
4. Management science specialist; and
5. Being a medical or non-medical but holding managerial position. This is in order to see if their speciality affects their management of the hospital as a whole.

The interview data attempted to provide a view of public and private management both in theory and in their practice. The researcher was prepared to encourage the interviewees to start talking and to indicate further illustration, if exemplification of a specific question was needed. However, the respondent had the opportunity to suggest his/her own point of view, which in some cases proved valuable as it disclosed information of which the researcher had been unaware.

The researcher experienced some difficulty in gathering data because most of the senior managers had limited time and were sometimes interrupted by staff members, patients or patients relatives. Some military hospitals restricted the release of data, resulting in delays in obtaining the data and limiting the number of interviews. It was necessary to rely on the questionnaires check list, which allowed more time for them to answer questions and possibly more frankly. It was intended that interviews, where possible, would cross-check responses.

5.2 Questionnaires

The questionnaire is a very common method of collecting data in social research (De Vaus, 1996). By definition a questionnaire is a list of questions by which information is sought from a selected group (Cohen and Manion, 1994). According to Wiersma (1986) and Al-Sabban (1990), the questionnaire is defined as a list of questions or statements to which the individual is asked to respond in writing and the response may range from a checkmark to an extensive written statement.

Any research investigation is time limited, and conducting fieldwork to gather sufficient data can be a time-consuming process. Therefore, a questionnaire was also used as a quick method of conducting a study. The researcher has only limited time to spend on a field-work, but requires a sufficient quantity of data to achieve success. It was partly for this reason that this study uses the questionnaire and interview techniques in order to obtain adequate information within the time limit.

Apart from the time limit, there was another reason for the use of the questionnaire. This is that the subjects under study involved chief executive directors, physicians and management staff, working in both self-managed and contracted-out management of different public health organisations, and at different geographical locations. They were too many to be observed in a particular situation at the same time. It was hoped that the respondents would have the opportunity to select their own time and obtain privacy stating their opinions. This type of research requires the gathering of sufficient data from a large sample within a limited time (Cohen and Manion, 1994). This is the fundamental reason for choosing the questionnaire as one of the data collection techniques in this study.

5.2.1 Advantages and disadvantages of questionnaires

The advantages of using questionnaires can be summarised as follows. They are easy to distribute, fill in, follow up, can be given to large numbers of respondents at the same time, and the data gathered is quantifiable (Al-Sabban; 1990; Gay, 1992; Cohen and Manion, 1994). The questionnaire is capable of eliciting data about a large population in a short time due to the reason that it lends itself easily to computer analysis software programme such as Social Package Statistical System (SPSS).

The main disadvantage with questionnaires is that there is no direct interaction between the interviewer and the respondent. Therefore, questionnaire must be carefully worded (Cohen and Manion, 1994; Al-Alawnah, 1996). For example, avoiding long and complicated question. Another concern of the questionnaire designer is to make sure that all questions are relevant and are important to the subject under study.

However, questionnaires also have a number of disadvantages. For example, the analysis of questionnaire data is time-consuming. Also, given that respondents are given plenty of time to think about their answers, respondents may skip some questions and may not be honest as the respondent may be afraid of stating anything which is not in the company policy or may displease superiors. Respondents may fear that they will be held responsible later for expressed views and so subject to unfavourable consequences. Often there could be collaboration between respondents rather than each giving their own view. Compared to interviews, questionnaires also tend to yield a low response rate (McKernan, 1991), but overall they help to gather reliable data.

5.2.2 Selection of questions

In preparation for selecting suitable questions for testing the thesis hypotheses, considerable research was undertaken into the literature on social science surveys, so that:

1) the questions would be relevant to the aims of the thesis and could be formed in such a way so as to avoid bias in favour of the research hypotheses;

2) as far as possible all elements of management would be covered: planning, organising, directing and controlling (Saati, 1984; Mookerjee, 1984; Armstrong, 1993; Harvey Jones, 1993; Al-Numer, 1994; Hanniagan, 1995; Muhana, 1998);

3) job satisfaction would be assessed, taking into consideration the situation in Saudi Arabia where (a) the management of most public hospitals was contracted-out to the private sector, (b) in the majority of cases, most of staff were non-nationals which could affect the management efficiency, effectiveness and the attitudes of Saudi staff towards non-Saudis being 'in charge' (Hickson and Pugh, 1995); (c) the staff felt uncertain about job security, and (d) self-management of hospitals was a recent experience (Maslow, 1942, Saati, 1984, Mookerjee, 1984, Harvey, 1993, Armstrong, 1993, Vecchio, 1995, Hannagan, 1995).

The job satisfaction questions were framed by drawing from experts in this field, including Maslow (1942), Harvey Jones (1993), Vecchio (1995), Hannagan (1995) and Hickson and Pugh (1995). Many of the comments made by social scientists and others who employed methods in relation to job satisfaction and management

training proved to be of particular value when designing the Questionnaire for this study, (see later section 'Questionnaire design'). Elcock (1995), in his paper entitled 'The Fallacies of Management' stressed that a dangerous fallacy is that there is a generic management method which private managers who have taken public sector jobs have found it hard to adapt to the very different culture of a government organisation. This statement emphasised the need to frame the majority of the questions so that the respondent judged the various aspects of management rather than being asked to make a judgment about which particular system of management was best for a certain aspect.

Various authors have commented on problems within organisations that reduced not only the efficiency and effectiveness of the organisation but also job satisfaction. Therefore, it was considered important to include, in the present study, questions that related to many of the stated problems.

Staff were frequently uncertain about their responsibilities. This was supported by Waznah (1996) and Al-Amri (1995). They suggested that statement about the specific management responsibility and job responsibilities should be in the form of a written instructions (booklet) stating the organisation's policies, job responsibilities, training opportunities, responsiveness to ideas that simplifying work procedures and achievements rewards. Harvey Jones (1995), Vecchio (1995) and Jung Shiang (1995) have also noted that job satisfaction can play an important in the management role to attract and retain qualified workers, he added that low levels of job satisfaction have been related to such problems as turnover, absenteeism, union-organising activity, and the filing of grievances. Thus job satisfaction is exceedingly

important for the well-being of the organisations' management as well as for the individual.

Hannagan (1995) found that a wide range of studies made that liaison between staff and senior management was frequently unsatisfactory under for their responsibilities. This view was supported by Jing Shiang (1995) and Al-Amri (1995). Staff absenteeism; poor prioritising of work; the right things done at the right time and the need to provide incentives were referred to in particular by Jing Shiang (1995).

Previous research into management problems relating job satisfaction raised a number of points which were of considerable value in framing suitable questions. These included making certain that a particular type of management was not appear as 'the best one; that responses could be obtained to various elements of management and that the respondents could express 'job satisfaction' in relation to a wide range of issues.

In framing suitable questions relating to job satisfaction in each management style of managers and their staff in Saudi public hospitals under study it was necessary to be aware of the difficulties and aim for, as far as possible to put questions which required would satisfy the requirement of the thesis.

5.2.3 Questionnaire design

On the bases of the literature review and the preliminary formal and informal interviews, the researcher was able to get an overall picture of the public hospitals contracting-out management in order to formulate the most important related questions. The questionnaires were to be structured around the four constituent elements of management science such as planning, organising, directing and

controlling, all of which are applied in both private management and public management. The questions were organised into five sections, one each centring on a management basic function element such as planning, organising, directing and controlling and in addition to employee's satisfaction as it improves efficiency. Three general questions were put to ascertain interviewees' general views regarding the concepts of contracting-out management, medical operation or any other services of public health care organisation. In addition to these general questions, questions were also asked about interviewee's specialities, position, experience, number of years in the health organisation, and their level of education (see chapter 6).

As noted above, questionnaires need to be carefully worded (Al-Sabban 1990; Cohen and Manion, 1994; Al-Alawnah, 1996). For this study, the researcher with the help of hospital managerial staff, selected 43 questions out of a possible set of more than 80 questions. The questions removed were considered either to be too long or not concerned directly with the management's main function. There were possible questions also, which, on reflection, were varieties of other questions and would therefore not contribute to the desired information. So these questions upon finding them not very directly relevant through consultations with experts, and through pilot studies, were removed so as to make the questionnaire concise and clear. This process led to the redesigning for the final questionnaire, which comprised 43 questions in two pages along with a covering letter. The questionnaire was ended with a bio-data section that asked the respondent for personal information. The logic behind putting the bio-data section at the end of the questionnaire, which is not standard practice, is to avoid causing any worries or inconvenience on the part of the respondent when he first meets personal questions which might prevent him from

proceeding through the questionnaire with the same level of honesty. Questionnaire version I, and the final version of Questionnaire version II are in Appendix I.

5.2.4 Questionnaire pilot study

In August 1997 the researcher prepared typed draft lists of the main relevant questions, which were given to 25 people who held Directors' positions, of whom seven had a medical background, thirteen had management science degrees, and five were management staff.

The objectives of this pilot study were:

1. To collect the related data;
2. To discover the related questions, difficulties, and the sensitivity;
3. To determine the appropriate size of sample;
4. To obtain the necessary personnel;
5. To find the appropriate time and costs of the work; and
6. And to add the relevant questions.

Prior to the fieldwork, the researcher visited the Ministry of Health General Director of Hospitals administration and contractual management & operation, and acquainted him with the purpose of the study. The researcher asked for lists of contracted-out and self managed-hospitals in different parts of the Kingdom. Hospitals which have contracted-out management and others which have had the experience of contracted-out management, full names and phone number of each hospital's General Director were provided. The researcher contacted each General Director of selected hospitals and fixed an appropriate time. An official letter was written, which included

information about the researcher, subject, and the objectives of the research, with a view to encouraging participants to help the researcher with the study. Prior to conducting the fieldwork of this research, a letter authorising access to the participants was received from the general director of King Khalid Military Academy to which the researcher belongs. Having made contact with the head of department in each selected hospital, the researcher then carried out considerable background research, including reviewing previous literature pertinent to the management basic elements as applied to contracting-out and self-management across various disciplines. Some preliminary interviewing was undertaken with both civil servants and private sector employees from different departments of some Ministry of Health hospitals, and some other government health agencies.

The information gleaned from this provided a substantial knowledge of privatisation conventions, and the communicative functions that tend to occur in public organisation management. The researcher learned the broader issues concerning the organisation of the health sector management, which in turn helped to shape the type of questions to be asked in the quantitative questionnaire's list (see Appendix I), and the qualitative semi-structured interviews. However, the researcher was not sure whether these questions were applicable to interviewees in the various public sectors. For example, not every public health sector organisation has the same contract terms and conditions for contracting-out management, nor do all private sector organisations follow the exact terms and conditions of public organisation.

The researcher had been employed as:

1- An Investigator of Personnel Affairs at King Khalid Academy Department for three years;

2- As a supervisor in the Purchasing Information and Expeditor Department (PIE), for one year at King Faisal Specialist Hospital and Research Centre (KFSH&RC);

3- Three years as senior Medical Equipment Purchaser and a member of Equipment Purchasing Requisition Committee (EPR) for equipment exceeding SR 5 million at King Faisal Specialist Hospital and Research Centre, which is one of the most modern public health care organisations in Saudi Arabia; and

4- An academic lecturer in Public Administration at King Khalid Military Academy. Therefore, he had established a good relationship with top, middle and lower management staff, not only in one public health organisation, but, also, with managers from other Public and Private health organisations through health management symposia, and the annual conventions of Saudi Public Administration. Thus, the researcher had the chance of making easy contacts with many managers and physicians who hold management positions, and had no difficulty in setting up appointments with them for preliminary questionnaires check list and interviews.

The researcher distributed a set of questions to 30 informants willing to participate in this pilot study. These informants were given a list of 75 questions. Based on their responses and suggestions, relevant questions were added, and unclear, badly worded, irrelevant or questions inapplicable to certain hospitals' management style were removed. In the final version of the questionnaire were 43 questions.

A questionnaire panel was called upon to vet the questions. The members of the panel were as follows: two from the King Saud University, three from the Institute of

Public Administration, and four who held Ph.D. degrees and directors' positions in the Ministry of Health. The researcher met with each of them and informed them about the nature of the study and invited them to provide comments and suggestions as to the organisation and content of the list of questions. All commented on the list and provided suggestions for improving the various aspects of these questions. Various issues concerning the length, the wording of questions were raised. The 76 original bilingual questions which were reduced and redesigned for maximum effectiveness.

5.2.5 Questionnaire distribution

There are three principal means to distribute/administer a questionnaire (Al-Sabban 1990; and Cohen and Manion, 1994):

1. Mailing: This can be sent to individuals or to groups by package post sent to distribute at reception counter. This is an expensive if a large number is to be sent out;

2. Self-administration: This is where the respondent completes the questionnaire in private and anonymously; and

3. Group-administration: This is where a number of people discuss the questions together with the compiler who builds a friendly atmosphere.

Each mode of questionnaire administration is used in a particular situation and for a different purpose. After due consideration it was decided that the best method for this situation was to co-ordinate with the Director General of contracted management and operation of MoH hospitals. He provided the researcher with the name, telephone number and the fax number of the Chief Executive of each of the hospitals

(contracted-out management and self-managed) that were to be included in this study.

An official letter from King Khalid Academy on behalf of the researcher was sent by fax to the General Director of each health organisation explaining the purpose of the study and the appreciation of participating for the completion of this study, and requesting that assistance be extended to the researcher. Batches of 100 questionnaires, accompanied by a covering letter from the Director of King Khalid Military Academy, to which the researcher is affiliated, were taken to each hospital. The researcher made personal contact with the General Director of each of hospital or his Deputy, who agreed and was willing to distribute the questionnaires to the relevant people by means of the organisation's internal mail, and requested the return of the completed questionnaires in two weeks time. The questionnaires were then handed over by the researcher to be distributed via the General Director or the Deputy Director, who provided a covering letter briefly explaining the purpose and expressing their opinion that this study may have benefits for the organisation.

5.2.6 Questionnaire structure

The Survey Check List consisted of only four pages, which implied that it would not take long to complete. The first page was a covering letter from the Chief Executive Director of Administration of each hospital, addressed to the survey participant of their hospital managerial staff seeking to co-operate with sincerity. The second page was a covering letter from the researcher to the participant, identifying himself, and assuring that the responses would be kept in complete confidence and would be used only for the purposes of this study. The researcher also included in this covering letter the definition of the term 'contracting-out management' and self-management'.

Page three was a 26 single-spaced statement questions check list. The following page has the completion to 43 statement questions and the last page has the categories of biographic data check list of the Survey Participant describing the positions, educational level, experience and so on (see Appendix I).

The questionnaire was aimed to evaluate the implementation of management's basic elements: planning, organising, directing and controlling, and to what extent the directors, managers and supervisors were aware of these elements and their implementation. This is because some of the managers and directors have an academic background as a physician but lack the sufficient qualification background in the field of management. Twelve statements were allocated to evaluate each management element. Some of these statements were found to be applicable to measure more than one element. Out of the total of 43 statements, twelve were selected to be more relevant to assess overall staff job satisfaction, and three general statements were aimed to evaluate hospital staff attitudes towards Contracting-out management as opposed to self-management (in-house management).

5.3 Sample population

The hospitals were selected to cover a variety of locations in different major cities. Staff surveyed included people in the more senior management position, and medical and management staff of the ten largest and most specialist governmental hospitals, located in the largest cities in the Kingdom, including Riyadh the capital city, Jeddah on the west cost, Al-Qassim to the north of Riyadh, Bishah to the south, and Dammam, and Al-Hassa to the east coast of the Kingdom. The researcher travelled to each hospital to deliver 50 Arabic copies and 50 English copies of the survey

Table 5.2: Name and location of hospitals distributed with questionnaires

Al-Imman Hospital	Riyadh
Armed Forces Hospital	Riyadh
King Fahad Hospital for National Guards	Riyadh
King Faisal Specialist Hospital and Research Centre	Riyadh
King Khalid Specialist Eye Hospital	Riyadh
Security Forces Hospital	Riyadh
Al-Amal Hospital	Dammam
King Saud Hospital	'Unayzah: Al Quasim
Prince Abdullah Hospital	Bishah: Abha: Asseer
King Abdul Aziz Hospital	Jeddah
Maternity and Child Hospital	Al-Ahsaa': Eastern Region

Source: author

questionnaires, knowing that most (if not all) hospital staff were reasonably fluent in the English language.

Of the 1,000 Survey Checklists (questionnaires) distributed, 160 were not returned, and 124 were returned incomplete. The incomplete questionnaires were taken out. This left 716 completed questionnaires, a response rate of 72%, which is very high for survey response rate. This high response rate could be attributed to the fact that the health care organisations involve highly educated personnel. Table 5.3 shows that 67% of the total respondents have university first degree or higher and they were aware that returns of research surveys have potential benefits. Moreover, this was perhaps due to their knowledge of how beneficial research studies are.

A list of higher positions of the respondents will show that these persons were randomly selected due to their role in decision-making within top, middle and lower management positions. They provided assistance in compiling the questionnaires and they also interviewed before and after the final questionnaire completed.

Table 5.3: Job titles of interviewees

Hospital Director	Associate Hospital Director
Administrative Affairs, Associate Executive Director	Health Systems Development Deputy Executive Director
Administrative Affairs, Associate Executive Director	Patient Services Department Acting Director
Exec. Director & Ancillary Services, Associate	Contracts & Supply Services
Academic Affairs Deputy Executive Director	Information Systems Associate Executive Director
Academic Affairs Associate Executive Director	Medical Affairs Executive Medical Director
Engineering Services Associate Executive Director	Planning, Organisation & Fallow up Associate Executive Director
Financial Affairs Associate Executive Director	Primary Healthcare, Health Affairs Associate Chief PHC
Public Affairs/ Anti venom Acting Director	Ambulatory & Primary Care Services Associate Hospital Director
Patient Services Associate Hospital Director	Logistics & Procurement Director
Primary Healthcare Executive Director	Medical Affairs Associate Executive Director
Staff Education Services Director	Nursing Services Assoc. Hospital Director
Anaesthesia Acting Director	Medical Staff Chief
Contracts Services Director	Medical Affairs Hospital Medical Director
Medical Co-ordinator & Eligibility Chief	Invest & Administration Audit Director
	Support Services Associate Hospital Director

Source: author

5.4 Duration of the fieldwork

Data collection for the study took place between August and November 1998. The field study was concentrated on and was conducted with special emphasis to senior and middle-management staff in the health care sphere and what influenced their

choice of particular management styles: in-house management or contracted-out management. Ten hospitals were examined, as this was considered feasible within the time limit: five had their management contracted-out to the private sector, and the other five were managed in-house. The aim was to find out whether there is an ideal management context, in which the management elements are implemented most efficiently, that is, whether contracted-out management is less or more efficient than in-house management for managing public health organisation in Saudi Arabia.

5.5 Methods of statistical analysis

Methods for analysing the data were those commonly used in social science surveys. First, each variable would be examined for which the responses would be given to the following assessments: 'Always', 'Most of the time', 'Sometimes', 'Seldom' and 'Never' and then the proportion of the whole would be given as a percentage. This simple method enables the researcher to make a simple estimate of the respondents' views.

When there are two sample populations, as in this research (contracted-out management and self-management), this is referred to as a two-sample problem on which it is possible to carry out statistically comparative analyses of mean, Z-value, t-value and p-value to show significance difference for 95% level of confidence (Moore, 1993). To compare the two population means, either by giving a confidence interval for $\mu 1 - \mu 2$, or by testing the hypothesis of no difference, $H0: \mu 1 = \mu 2$. Therefore, variables are measured for both management system and for statistical symbol's definition (see Table 5.4). The researcher used the Statistical Package for Social Science (SPSS) to facilitate the statistical analyses.

Table 5.4: Statistical definitions

Population	Sample size	Variables	Mean	Standard deviation
Contracted-out management respondents	n1	X1	μ1 (μc) or $\bar{x}$1	S1 or σ1
In-house management respondents	n2	X2	μ2 (μs) or $\bar{x}$2	S2 or σ2

5.5.1 Statistical mean

The mean is extensively used as a useful indicator of group performance. Evaluations often focus major interest on mean scores from groups of participants since large-scale programmes generally aim at improving the general performance or attitude level of groups receiving various programmes rather than concentrating on the performance of individual respondents' score.

The mean is the arithmetical average of a frequency distribution. The formula for calculating single data is:

$$\text{The Mean } \bar{x} = \frac{\sum x}{n}$$

where x = each observation score
n = the total number of respondents
$\sum$ = the sum

It provides us with a view of where the approximate 'middle' of a set of data lies; that is, it is a measure of central tendency.

One of the primary advantages of the mean as a measure of location is that if we have a mean for each of several samples and want to find the mean of the sample which results when the several samples (in the case of this thesis, valued assumptions) are combined this can be easily done.

The mean depends on the set of scores. If the scores are unimodal and tend to cluster fairly close together, then the mean will be a meaningful representation of the data. Stating the mean is appropriate in statistical tests, so as to obtain a guide estimate of a group's performance. So the mean is the large frequency observation distribution by means of a simple value. This is the reason why it was determined in this study.

In order to estimate the mean of each variant the value assumptions were each given a figure. For 'Always': 5; 'Most of the time': 4; 'Sometimes': 3; 'Seldom': 2; and 'Never': 1. The mean in this case being 3.0, however, when the actual data is analysed it may be necessary to readjust the value of the mean in order to test for significance by means of Z-value, t- value and p-test (Chapter 6).

5.5.2 Z-value

A Z-value tells you how far from the mean of a distribution the score was, and 'how far' is measured in terms of standard deviations. Therefore, a Z-score locates a score in a given distribution and, also, a Z-score tells how many deviations away from the mean the raw score is, (Fitz-Gibbon and Morris, 1987).

$$Z\text{-value} = \frac{\text{raw score - mean}}{\text{standard deviation}}$$

However, the mean (>3.5) was chosen by the researcher to be a true Mean as reasonable marker as ratings of 1,2,3 suggest negative responses and 4 and 5 positive

responses, so the cut off between negative and positive lies between 3 and 4 (means give possibility of any score between (1 and 5). Thus (M = 3.5), as the appropriate value for the statistical mean.

The investigation of which the variables of the management elements' variables is appear to be actively effective or needs to be given management attention. So, for each variable the test of performance will show higher than (M=3.5), and so the Z-scores to test whether the mean is in fact 3.5 or not, by given Z-value = 1.65 and higher.

The value Z = 1.65 is referred to as the tabled critical one-tailed 0.05 Z- value. This value is employed since the proportion of cases in the normal distribution that falls above Z-value = +1.65 or below Z-value = -1.65 in each tail of the distribution is 0.05. If Z- $\in$ -1.65, 1.65 there is not enough evidence to suggest the mean is not 3.5.

5.5.3 The t-test

The t-test is a test to see if there is a statistically significant difference between the mean scores of the two groups, such as contracting-out management variables and the self-managed variables. The t-test takes into account two factors - group size and score variability - when interpreting the difference observed between the groups. It shows that given the variability of scores in the two groups, the difference between means is not big enough to reach statistical significance (Rice, 1995).

$$t = \frac{(\bar{x}_1 - \bar{x}_2) - (\mu_1 - \mu_2)}{\sqrt{S_p\left(\frac{1}{n_1} + \frac{1}{n_2}\right)}}$$

Where:

$\bar{x}_1$ mean in the first group (contracting-out management)

$\bar{x}_2$ mean in the second group (self-management)

M_1 the first populations mean (contracting-out management)

M_2 the second population means (self-management)

S^2p pooled sample variance

n_1 sample size first group(contracting-out management)

n_2 sample size second group (self-management)

The use of the above equation of t-test is helpful, to search out statistically significant differences between any two groups that one can identify on any measure one can administer. The t-value is therefore important in a case where the difference between two systems may appears numerically small as occurred when the questionnaire data was analysed.

5.5.4 P-value

The p-value test evaluates a test statistic in reference to a sampling distribution. The result is compared to a binomial distribution (identifying all possible values). The researcher can then decide whether to treat a difference as a 'true' difference or mere chance. Once a t-value has been obtained or the z- value for a larger sample size >30 (Pagan, 1998), the associated p-value can be drawn up to represent the distribution that would result from reported random sampling for the entire population to test the validity of the null hypothesis (Cohen and Marion, 1994).

In the case of analysis of the data obtained from the questions for this thesis it was necessary to determine whether the data obtained by estimating the t-value was actually significant or could have occurred by chance. P-score is 0.95 because the

probability of observing a value of at most 1.65 from the normal distribution. In only 1 in 20 cases would expect an observation greater than 1.65 from the normal distribution. Thus, under the null hypothesis, large z-scores suggest an unlikely reading from the normal distribution with mean 0 and standard deviation 1, arguing against the null hypothesis that the true mean is 3.5.

5.6 Summary

This chapter has presented the methodological tools on how data were gathered from fieldwork. Advantages and disadvantages of methods used for data collection, sample size and the types of statistical analysis that the researcher have been considered. The reasoning behind the types of research methods chosen has been given, along with how these methods were administered, and subsequently analysed to give exact meaningful answer to relate the data to the research subject.

From the data analysis obtained from employing both interview and questionnaire techniques it can be determined whether the views of the respondents can be measured as accurately as is possible, bearing in mind that the views expressed would be subjective. The semi-structured interview method was chosen because literary research showed it to be the most appropriate method for the subject. The questionnaire method involved the use of questions deemed both by experts in the fields of public, business and health sector management and the researcher's own experience to be appropriate to the situation, not least in that they avoided possible bias on the part of the designer.

The methods of analyses employed were selected to be appropriate to the situation: types of test analyses were chosen which not only would determine differences but also would test their significance.

Chapter Six

Presentation and Discussion of the Survey

6.0 Introduction

This chapter presents and discusses data gathered from hospital staff who work in public hospitals in Saudi Arabia. The views of respondents are considered regarding public administration policies and the efficiency and effectiveness of management in public hospitals, both in cases where the hospital is self-managed by an in-house management team and also where the management has been contracted-out to a team hired by a commercial company. In order to evaluate the efficiency and effectiveness both of contracting-out and in-house management's in Saudi Arabia's public hospitals, the basic elements of management will be assessed by examining and analysing the views of hospital staff. The results from responses to the questionnaires are presented in tabular form, analysed and statistically tested using the Statistical Package for Social Science (SPSS) (Rice, 1995). This chapter answers the research hypotheses stated in Chapter One.

To test Hypothesis Two, the data is examined about the extent to which public hospital staff consider hospitals in which management has been contracted out to be better managed than hospitals with an in-house management team for only non-medical services, or for only medical services, or for all hospital services.

Three final questions the questionnaire list were put to respondents to examine their views regarding which hospital services are better managed by contracted-out management rather than in-house management. Their responses were analysed according to their job position on the hospital staff, their level of education, and their nationality. This answers Hypothesis Two of this thesis.

Chapter Two of this study examined data gathered from the literature review regarding public administration and public management, and the drive towards greater efficiency through privatisation, with a focus on the success of public administration in contracting-out management of public organisation management services. In this chapter, the data gathered from the questionnaires and interviews on contracted-out management in public health hospitals in Saudi Arabia are presented and discussed.

Analysis of responses to the questionnaires is followed by analysis involving the calculation of percentages, means, Z-value, p-values, and t-test to test the true mean, and whether there is a significant difference between management styles. These techniques were useful in providing clear and significant answers for the research hypotheses stated in Chapter One. Information presented under the subheadings of management basic functions: planning, organising, directing and controlling provide answers to the questions formulated to investigate the efficiency and effectiveness of contracted-out management teams and in-house management teams. Included in the data analysis was an additional subheading relating to employee satisfaction. All of these five functions are major factors in any organisational efficiency and effectiveness. This is why they were included in the analysis of the data collected in this study to assist public administration policy in the process of decision-making regarding whether to continue with contracted-out management or else to replace it with self-managed hospitals in the public health sector.

In Chapter Seven data obtained from interviews, conducted by the researcher in Saudi Arabia between 4 March 1999 and 24 May 1999, to validate the questionnaire responses, and to cover other managerial aspects not included in the questionnaire, are analysed.

6.1 Respondents' biographical data

The respondents' profile included a description of their education attainment, position in the institution's hierarchy, and experience in terms of years of employment in the Health sector, previous experience, gender and nationality. The respondents were from ten Government Hospitals selected at random from different regions of the Kingdom to represent whole population. There were five contractual management operated hospitals, and in-house management operated in the other five hospitals (Table 6.1).

Table 6.1: Respondents from both management styles

Management styles	Number of Respondents	
Contracted-out hospitals (Private management)	373	52%
Self-managed hospitals (In-house/ public management)	343	48%
Total Respondents	716	100%

It should be noted that some military hospitals had restrictions on releasing data, therefore, it took more time to obtain the responses than was anticipated, which delayed data collection and the analyses of the total number of the questionnaires. contracted-out management hospitals respondents from 52% of the total sample from Government hospitals that are operated by in-house management had 48% respondents, a difference of only 4%, which could be too small to have any significant effect.

6.1.1 Respondents' nationality

Respondents' nationality, Table 6.2 shows that 48% of the total respondents were Saudis, and 52% were non-Saudi. Only two respondents did not indicate their nationality. It can be ascertained that the public hospitals which have contracted-out management employ fewer Saudis, 37% as compared with in-house management hospitals was 59% were Saudis. It can be concluded from these figures that there is a shortage of skilled Saudi manpower in most specialities (Al-Amri, 1995; Al-Nughimshi, 1997).

Table 6.2: Respondents' nationality

Respondents Nationality	Contracted-out Management Respondents	Self-management Respondents	Grand Total Respondents
Saudi	139 (37%)	203 (59%)	342 (48%)
Non Saudi	232 (62%)	140(41%)	372 (52%)
Missing	2 (01%)	0.0	2(0.3%)
Total	373 (100%)	343 (100%)	716 (100%)

The respondents in contracted hospitals' management have 62% non-Saudis, whereas the figure for in-house managed hospitals have 41%, which means more Saudi nationals work under in-house managed hospitals than for the contracted management. This could be evidence that Saudi staff prefer in-house management, pays more, and/ or better job stability or for other benefits than in the contracted management, (ibid). Having non-Saudi national opinion of their experience of private management (contracted-out management) would be very valuable to this study.

6.1.2 Respondents' education level

When the education level of the total respondents was examined, Table 6.3 shows that whilst 30% were not educated above A level standard, two-thirds held a university first degree or above: which indicate that most of the respondents well educated. This large size of educated respondents has yielded a high rate of responses and may respond a more useful data.

Table 6.3: Education attainment of respondents

Education Attainment	Contracted-out Management Respondents	Self-Management Respondents	Grand Total
No university degree	102 (27%)	112 (33%)	214 (30%)
University first degree	183 (49%)	117 (34%)	300 (42%)
University higher degree	66 (18%)	110 (33%)	176 (25%)
Not stated	22 (6%)	4 (1%)	26 (3%)
Total	373 (100%)	343 (100%)	716 (100%)

When comparing the two categories of hospitals (Table 6.3), just over a quarter (27%) of respondents at the contracted-out management hospitals held qualifications lower than a university degree, whereas at the self-managed hospitals this figure rose to almost a third (33%). However, the situation was reversed when it came to university first degrees: almost half (49%) of the respondents at contracted-out management hospitals had university first degrees, compared with only a third at the self-managed hospitals. The situation was reversed again with regard to higher degrees, less than one fifth (18%) of the respondents at contracted-out management hospitals had university higher degrees, compared with a third at the self-managed hospitals. This

shows that self-managed hospitals employ a workforce with a wider range of educational attainment, whereas the contracted out management hospitals favour people with university first degrees. This latter could be because it is cheaper to employ persons without higher degrees (Al-Mashoug and Al Ghaith, 1996; Al-Nughimshi, 1997).

In-house managed hospitals have slightly more (5%) of employees with no academic qualifications than is found in the contracted-out hospitals. This may due to notional staff trainee programmes which staff can be trained on the job. Staffs who do not possess university qualifications form 33% of the total such as 6% more than was found in contracted-out management. That approximately one-third of respondents have no higher qualifications under both systems could be due to the lack of suitably qualified available people or that the hospital, for some reasons possibly budget constraints or a desire to employ Saudis or non-Saudis as the case may be and institute their own training programmes, (Hagan, 1995).

6.1.3 Respondents' positions

Respondents' positions within hospital management systems: 36% of whom were only directors / managers, and 44% were medical staff. However, some of these latter may have directorial / managerial positions, sharing hospital management decision-making. For instance, a hospital medical director sometimes acts in the position of Chief Executive Director for most of public hospitals in the Kingdom (see Table 6.4).

Contracted-out hospitals' management has about 38% who hold Directors / Managers positions, 23% are non-medical and 39.4% were medical staff. Of the in-house managed, Directors and Managers from 35%; 17% are non-medical staff and 48% is the percentage of medical staff.

Table 6.4: Respondents' positions

Respondents' Positions	Contracted-out Management Respondents	Self-management Respondents	Grand Total Respondents
Directors / Managers	140 (38%)	119 (35%)	259 (36%)
Non-medical staff	85 (23%)	59 (17 %)	144 (20%)
Medical staff	147(39%)	165 (48%)	312 (44%)
Not known	1 (0.3%)	0.0	1 (0.1%)
Total	373 (100%)	343 (100%)	716 (100%)

The most significant difference is that Self-managed hospitals appear to employ a higher proportion of medical staff (48%) in their hospitals, compared with contracted-out management hospitals (39%) (Al-Kuraim, 2000).

6.1.4 Years of experience in the organisation

The importance of respondents' years of experience in their respective organisation, may indicate variously: job satisfaction, belief in their job's stability, and opportunity for advancement, knowledge of the organisation's, purpose and aims. Of the total respondents of contracted-out management hospitals, 15.5% have less than three years of experience of this type which may be the reason of the normal contract period is three years, (see Table 6.5).

Table 6.5: Respondents' years of experience in this organisation

Respondents **Years of Experience**	Contracted-out Management Respondents	Self-management Respondents	Total
Less than 3 years.	58 (16%)	155 (45%)	213 (30%)
From 3-6 years	176 (47%)	54 (16%)	230 (32%)
From 7-10 years	110 (29%)	73 (21%)	183 (26%)
More than 10 years	27 (07%)	61 (18%)	88 (12%)
Missing	2 (01%)	0.0	2 (0.3%)
Total	373 (100%)	343 (100%)	716 (100%)

However, 47% have been working for it for the past 3 to 6 years, which indicates that most of manpower had their contracts extended for another three-year period. However, 30% had been there from 7 to 10 years and 07% have been working for more than 10 years in the same organisation regardless of the type of contractor inferring that s/he was satisfied with their job and organisation.

At in-house managed hospitals 45% have less than three years experience. This marked difference with the contracted out management hospitals (16%) could be because of the pressure of nationals (Hickson and Pugh, 1995; Al-Mashouq and Al-Ghith, 1996), as shown in the nationality table. 16% have been working for 3 to 6 years, 21% for 7 to 10 years and 18% have been working for more than 10 years. This indicates that more than 10% of staffs stay in the same organisation for lengthy periods as this normally of terms and conditions of the contracts.

A far greater number of staff (45%) has been employed in the in-house managed hospitals than in the contract-out hospitals management (16%) can be for less than 3 years. This situation is shown in 'Respondents' positions' (Table 6.6), that the in-house managed attract Saudis to fill vacancies and that many of them are relatively newly qualified.

6.1.5 Respondents' previous experience

Table 6.6, shows that contracted-out management hospitals, well over a third of respondents (37.8%) had more than 10 years experience; almost a quarter (22.3%) had between 7 and 10 years experience; nearly a third (29.8%) had between 3 and 6 years experience; and only one tenth (10.2%) had less than 3 years experience.

This contrasts sharply with respondents from self-managed hospitals, in which nearly half (45%) have less than three years experience of this type of management, and only less than one fifth (18%) have ten or more years experience. The reason for this sharp difference is likely to be due to the fact that self-management is a relatively newly introduced system.

Table 6.6: Years of previous experience

Previous experience	Contracted-out Management Respondents	Self-management Respondents	Total Respondents
Less than 3 years.	38 (10%)	154 (45%)	192 (27%)
From 3-6 years	111 (30%)	67 (20%)	178 (25%)
From 7-10 years	83 (22%)	62 (18%)	145 (20%)
More than 10 years	141 (38%)	60 (17%)	201 (28 %)
Missing data	0.0	0.0	0.0
Total	373 (100%)	343 (100%)	716 (100%)

This difference can be explained by taking into consideration three factors:

1) The Saudisation programmes, which wants concentration on employment of Saudi, training of Saudis, and encouragement of Saudis to be involved in a wider variety of professions and to work with the private sector (Sixth Five Year Development Plan, 1995, Manpower Council, 1997).

2) Compared with hospitals with contracted-out management, self-managed hospitals show greater readiness to employ Saudi personnel who are less well qualified, to be trained on the job.

3) Fewer Saudi people seek employment outside family areas where, formerly, they would be expected to work (Al-Nughimshi, 1997).

6.1.6 Respondents' gender

Respondents' genders were two thirds (65%) male and one third (34%) female. The reason why the gender of the respondents was recorded on Table 6.7 was to show that respondents came from both sexes. The proportion of women was lower because women are less involved in the management sector. Women are employed mainly in separate sections, mostly concerned with female patients.

Table 6.7: Respondents' gender

Respondents Gender	Contracted-out management respondents	Self-management Respondents	Total respondents
Male	244 (65%)	201 (59%)	445 (62%)
Female	126 (34%)	142 (41%)	268 (38%)
Missing	3 (1%)	0 (0%)	3 (0.4%)
Total	373 (100%)	343 (100%)	716 (100%)

In hospitals with contracted-out management, almost two thirds (65%) of respondents were identified as male, and just over one third (34%) as female. In self-managed hospitals the proportions changed a little: only 59% of respondents were identified as male, with 41% of respondents female. There is, therefore, a 5% difference in gender related employment in both systems.

When comparing the respondents' gender in both types of management systems it can be ascertained from Table 6.7 that in contracted-out there is a slightly greater percentage of men than in self-managed, that is 6%. This is due to the fact that with contracted-out tendency is to employ more of non-nationals, as cheaper manpower, where females tends to be more in in-house managed hospitals.

6.2 Analysis and discussion of management functions

Mookerjee (1984:35-54) argued, 'Better Management means better Economy' where the economy, social and political goals rest upon the competency of the manager and that management provides effectiveness to human efforts. He also believed that knowledge of management should be obtained and when the science of management increases, the art of management also increases.

This section analyses and comments on responses to statements related to the main four aspects of management i.e. (planning, organising, directing controlling and staff satisfaction) as applied to contracted-out management and self-management in public health care organisations.

6.2.1 Planning variables

Information under each subheading provides answers the questions formulated to investigate the management's basic elements: Planning, Organising, Directing, Controlling and, also, Employee satisfaction which are the major factors in any organisation's management in order for it to achieve efficiency, productivity and effectiveness (Muhana, 1998; Higan, 1999).

Management planning is the first of management's functions, which are concerned with setting out the following variables i.e. clear objectives, plan specific procedures, issuing instructions, and establishing training programmes etc. (see Table 6.8).

For management planning, there were 12 statements requiring responses in order to evaluate its clarity and effectiveness, so in those are important for the staff that they are aware of their duties, and to have job security. Those statements reflect the

successive steps and conditions required to reach an organisation objective, (ibid, Muhana, 1998:90-92).

From the responses results displayed on Planning Table 6.8 we can compare the opinions of the respondents as to how they evaluate their organisation's planning of its activities. When determining whether comparing Contracted-out or Self /In-house management was 'always better' it can be seen from Table 6.8, which displays the responses to each valuation as percentages, that for certain activities e.g. Departmental objectives (Q1); work procedures (Q2); written management instructions(Q3); Saudi staff doing important tasks (Q5) and working on technologically advanced equipment (Q6), the difference between those variables in both management systems is very little i.e. under 3%.

However, these differences estimated by the use of percentage estimation do not provide much difference meaningful figures, therefore, other methods of statistical analyses were employed: mean, Z-value, p-value and t-test to obtain a true significance differences, (see Chapter 5 for more explanation).

Table 6.8: Analysis of planning variables (by percentage)

No.	Planning Variables	Management Style	AL	MO	SO	SE	NE	MI
1	Department objectives are clear	Contracted Management	203 54%	110 30%	38 10%	17 5%	5 1%	0
		Self-Management	184 54%	111 33%	25 7%	5 1%	15 2%	2
2	Work procedures are clear	Contracted Management	177 47%	132 36%	41 11%	17 5%	5 1%	1
		Self-Management	120 35%	157 46%	36 10%	14 4%	16 5%	0
3	Written management instruction	Contracted Management	101 27%	107 29%	89 24%	45 12%	31 8%	0
		Self-Management	90 26%	129 38%	90 26%	14 4%	20 6%	0
4	Jobs are stable in this institution	Contracted Management	83 23%	87 24%	67 18%	28 8%	102 28%	6
		Self-Management	58 17%	118 35%	74 22%	28 8%	63 18%	2
5	Saudi staff hold key positions	Contracted Management	142 38%	92 25%	58 16%	27 7%	51 14%	3
		Self-Management	121 35%	110 32%	59 17%	21 6%	31 9%	1
6	Saudi staff using high tech. equipment	Contracted Management	71 20%	78 21%	73 20%	49 13%	94 26%	8
		Self-Management	71 21%	104 30%	81 32%	31 %9	55 16%	1
7	Equipment maintenance satisfactory	Contracted Management	96 26%	128 35 %	81 22%	33 9%	32 8%	3
		Self-Management	58 17%	149 44%	80 23%	28 8%	26 7%	2
8	Medical staff skills are satisfactory	Contracted Management	89 24%	160 44%	83 23%	22 6%	12 3%	7
		Self-Management	55 16%	170 50%	87 26%	15 04%	14 04%	2
9	Hospital has good retirement scheme	Contracted Management	53 15%	46 13%	34 10%	34 10%	181 52%	25
		Self-Management	31 10%	75 23%	47 14%	30 09%	143 44%	17
10	Equipment always available	Contracted Management	93 25%	131 35%	97 26%	34 9%	17 5%	1
		Self-Management	59 17%	142 42%	81 24%	27 08%	33 10%	1
11	Hospital increase services	Contracted Management	70 19%	80 22%	98 27%	65 17%	55 15%	5
		Self-Management	65 19%	93 28%	103 31%	44 13%	32 09%	6
12	Hospital's health awareness	Contracted Management	123 33%	95 25%	79 21%	38 11%	36 10%	2
		Self-Management	91 27%	91 .27%	101 .28%	30 09%	26 08%	4

AL; Always, MO: Mostly, SO: sometimes, SE: Seldom, NE: Never, and MI: Missing response.

From the results shown in Table 6.9 it can be seen that out of the 12 variables both management systems obtained positive responses, i.e. significantly higher than the calculated mean and Z testing for four variables: 'Departmental objectives are clear'; 'Work procedures are clear'; 'Medical staff skills' and 'Availability of technology'. No significant difference was calculated between 'Job stability' and Hospital has a good retirement scheme'. Where there was a significant difference between both systems was in 'Availability of technology', where 'contracted management' scored significantly higher (determined by Z values) and in 'Management instructions are written', 'Hospital increases services' and 'Saudi technical staff' where the self-management system scored higher than contracted management'.

Table 6.9: Analysis of planning variables

No.	Planning Variables	Contracted Management		Self-Management		Significance difference
		Mean	Z	Mean	Z	t-value
1-	Department objectives are clear	4.31	17.00*	4.29	14.2*	-0.275
2-	Work procedures are clear	4.23	15.30*	4.02	9.4*	-2.894
3-	Medical staff skills	3.80	5.85*	3.70	3.88*	-1.255
4-	Availability of Technology	3.67	3.01*	3.49	-0.185	-2.391
5-	Saudi staff hold key positions	3.67	2.33*	3.79	4.25*	1.2069
6-	Hospital health awareness programme	3.62	1.78*	3.56	0.92	-0.640
7-	Equipment maintenance	3.60	1.59	3.54	0.736	-0.690
8-	Management instructions are written	3.54	0.62	3.74	4.07*	2.301
9-	Hospital increases services	3.12	-5.52	3.34	-2.4	2.308
10-	Jobs are stable in this institution	3.06	-5.51	3.23	-3.7	1.578
11-	Saudi Technical staff	2.95	-7.15	3.23	-3.7	2.650
12-	Hospital has good retirement scheme	2.30	-14.35	2.45	-12.78	1.283
Over all Mean		3.49		3.53		
t- value = -0.203		df = 22,		**p – value = 0.841		

* Significant at level (0.05), where Z- value >1.65, level of confidence (0.95).
** Significant at level (0.05), where p- value < .05, level of confidence (0.95).
H0: Mean (μ)< 3.5
H1: Mean (μ) > 3.5

In relation to Hypothesis One it can be seen that in the case of planning there is no overall significant difference between both systems. When the t-test was applied to the results it was found that in three cases: 'Written managerial instruction'; 'Hospital increases services' and 'Saudis employed in high-tech', self-management scored higher than contracted.

Of the responses, to certain variables, which resulted in scores lower than the true mean, it appears that in order for both the hospitals to be highly efficient and have effective management, planning of some of the various aspects/variables needs to be improved. However, it is highly unlikely that any system of management can be completely efficient at all times (Hickson and Pugh, 1995; Hannagan, 1995). For the ones listed in Table 6.9 'Job stability' and a 'Good retirement scheme' need immediate attention if management wants a secure future for their hospitals. This is of particular importance in the ever-extending demands on the country's health service (see Chapter 5).

The first method of comparison in Table 6.8 was by comparing percentages in order to see if there was an easily noticeable difference. However if the differences between variables in both systems were low then other methods of statistical analysis would prove more significant. These methods as detailed in chapter 4 were as follows;

By examining Table 6.9, which assesses the Planning variables by establishing the true $\mu = 3.5$ which is the acceptable scores of the Sometime response is = 3, which is the unsure response, and the Mostly response is = 4, however, ($\mu > 3.5$) is the more definite response, which is the reason of chosen the true mean (μ)to be > 3.5, therefore, in the analysis for both management systems and the Z- values to be >1.65 to support the hypothesis, i.e. H0 = $\mu < 3.5$ and H1 = $\mu > 3.5$, (Stevens, 1996).

In this experiment, a sample was generated from the contractual- management hospitals and a sample from self-management. The assumption was that these samples are independent of each other. The aim then was to examine in order to determine whether there is a statistically significant difference between the two samples, i.e. the difference is non-zero then this suggests one of the management type is "better". A rational estimate of the difference is the difference in the means of the respective samples. If contracted-management hospitals, the mean (μc), are better than Self-management hospitals the mean (μs), then would expect the difference, then the result of $\mu c - \mu s$, to be positive and the Z-value would show so. If the Z-value is negative that is means the $\mu c - \mu s$ result was negative, this also would have t-test result less than (+ or -1.65), which would indicate no significance difference and the p-value is > .05 (see chapter 5).

Table 6.9, shows each variable of the planning variables: the clarity of departmental objectives (Q1); the contracted-out management mean is 4.31: for self-management 4.29, Work procedure (Q2), the contracted-out management of a mean is 4.23: for self-management 4.02. Medical staff skill (Q3), in the contracted-out management has a μ= 3.80: for self-management μ= 3.70. Availability of the Technology (Q4), the contracted-out management of a μ= 3.67: for self-management 3.49. The Saudi staff occupying key positions (Q.5), the contracted-out management has a μ= 3.67: and for self-management μ= 3.79. For Equipment maintenance, the contracted-out management μ= 3.60: self-management 3.54 and for the management written instructions (Q.8) has in the contracted-out management of a μ= 3.54: where in Self-management μ= 3.74 slightly higher, Even though they all have a very good indicators. In Hospital New Services increase (Q.9), the contracted-out management has the mean of 3.12: where also shows better in self-management as μ = 3.34. Job

security (Q10), for the contracted-out management μ = 3.06: when for Self-management the Mean is again slightly higher μ = 3.23. And for Hospitals retirement scheme (Q.12), in the contracted-out management has a mean of 2.30: where Self-management 2.45. In other words, in terms of the management element of planning variables, the responses from respondents show that both management styles are about equal to each other.

6.2.3 Organising variables

Organising is the second of the management's basic elements. It is often referred to synonymously with management. It deals with job responsibilities are clear (Q1), for decision-making, and qualified personnel so as to have successful accomplished, Fincham and Rhodes, (1994). This requires job description for every position, so to be selective on recruitment, and use training to develop unskilled personnel. All the above activities are major parts of the organising element of management, which are included in Table 6.10.

Organising, in contracted-out management and self-managed hospitals, was tested by seeking responses to 12 variables. The responses are expressed in percentages when comparing both management systems. By first considering the 'Always', it emerged that in 7 out of 12 aspects there is only 3% or less difference between the variables applied in both management systems and for Recruitment of Qualified Nationals (Q.6), hospitals with contracted-out management had a 3% greater response than self-managed hospitals. The attendance of Conferences in Management showed 8% more favour of contracted-out management. The aspect with the greatest difference is Rapid Response in emergency cases. Hospitals with contracted-out management scored 36%

compared with only 20% for the self-managed hospitals, i.e. a 16% difference in favour of contracted-out management.

Table 6.10: Analysis of organising variables (by percentage)

No	Organising Variables	Management Style	AL	MO	SO	SE	NE	MI
1	Job responsibilities are clear	Contracted-out	258 69%	84 22%	24 6%	3 1%	3 1%	1
		Self-managed	245 72%	76 22%	13 4%	2 1%	5 1%	2
2	Position requirements are clear	Contracted-out	106 29%	119 33%	72 20%	32 9%	34 9%	8
		Self-managed	97 29%	148 44%	62 18%	17 5%	15 4%	4
3	Rapid response in emergency cases	Contracted-out	135 36%	116 31%	68 18%	22 6%	32 9%	0
		Self-managed	69 20%	108 32%	86 25%	32 9%	46 14%	2
4	Flexibility to simplify work procedure	Contracted-out	87 24%	134 36%	103 28%	33 9%	13 3%	3
		Self-managed	89 26%	121 35%	87 25%	28 8%	17 5%	1
5	Saudi staff undertake important tasks	Contracted-out	142 38%	92 25%	58 16%	27 7%	51 14%	3
		Self-managed	121 35%	110 32%	59 17%	21 6%	31 9%	1
6	Qualified Nursing staff employed	Contracted-out	102 28%	112 30%	70 19%	44 12%	41 11%	4
		Self-managed	56 17%	149 44%	87 26%	23 6%	25 7%	3
7	Job description is clear	Contracted-out	116 32%	79 22%	75 20%	39 11%	57 15%	7
		Self-managed	119 35%	90 26%	69 20%	23 7%	41 12%	1
8	Recruitment of qualified national manpower	Contracted-out	68 19%	92 26%	105 29%	48 13%	47 13%	13
		Self-managed	50 15%	117 34%	109 32%	39 11%	25 7%	3
9	Staff participate in decision making	Contracted-out	62 17%	102 28%	97 26%	45 12%	65 17%	2
		Self-managed	41 12%	132 39%	97 28%	32 10%	34 10%	1
10	Experience exchange with other hospitals	Contracted-out	47 14%	77 22%	90 26%	62 18%	68 20%	29
		Self-managed	55 16%	105 31%	82 24%	46 14%	53 15%	2
11	Saudi staff use high tech. Equipment	Contracted-out	71 20%	78 21%	73 20%	49 13%	94 26%	8
		Self-managed	71 21%	104 30%	81 24%	31 9%	55 16%	1
12	Management conference attendance	Contracted-out	64 17%	83 22%	69 19%	42 11%	114 31%	1
		Self-managed	31 9%	88 26%	77 23%	48 14%	97 28%	2

AL; Always, MO: Mostly, SO: sometimes, SE: Seldom, NE: Never, and MI: Missing response.

However, when difference estimated by the use of percentage were so close, estimation does not provide meaningful difference figures. Therefore, other methods of statistical analyses were employed (mean, Z-value and p-value; Chapter 5) to be obtain a true significance for each variable and a group of variables (Table 6.11).

Table 6.11: Analysis of organising variables

No.	Organising Variables	Contracted Management		Self-Management		Significance difference
		Mean	Z	Mean	Z	t-value
1-	Job responsibilities are clear	4.59	29.20*	4.62	28.8*	0.556
2-	Position requirements are clear	3.88	2.07*	3.87	6.6*	-0.051
3-	Rapid service in emergency cases	3.80	4.71*	3.36	-2.02	-4.682
4-	Flexibility to simplify work procedure	3.67	3.14*	3.69	3.22*	0.251
5-	Saudi staff hold key positions	3.67	2.33*	3.79	4.3*	1.207
6-	Qualified Nursing staff employed	3.51	0.14	3.55	.002	0.441
7-	Job description is clear	3.43	-0.93	3.65	2.09*	2.116
8-	National human resource	3.24	-3.88	3.38	-2.01	1.555
9-	Staff participate in decision making	3.14	-5.25	3.37	-2.11	2.480
10-	Experience exchange with other hospitals	3.07	-6.00	3.18	-4.55	1.092
11-	Saudi staff work on equipment	2.95	-7.15	3.31	-2.64	3.407
12-	Management conferences	2.84	-8.54	2.73	-10.55	-1.030
	Overall Mean	3.48		3.54		
t- value= -0.307		df = 22,		**p – value = 0.7617		

* Significant at level (0.05), where Z- value >1.65, level of confidence (0.95).
** Significant at levels (0.05), where p- value < .05, level of confidence (0.95).
H0: Mean < 3.5
H1: Mean > 3.5

Again, as occurred when examining the responses to the management element of 'Planning variables', the percentage obtained from responses to the Organising variables needed further interpretation so as to make sure to test their true significance. The same methods of analysis were applied, which gave the following results in Table 6.11, shows that of the 12 possible variables tested for both systems, four showed results higher than the true mean >3.5 , its significance determined by the Z-value. These were 'Job responsibilities are clear' (Q.1); 'Position requirements

are clear' (Q.2); 'Flexibility to simplify work procedure' (Q4); and 'Saudi staff hold key positions' (Q.5), Apart from 'Job description is clear' (Q.7), where the Self-managed system was significantly higher than the acceptable mean, 'Rapid service in emergency cases' (Q.3), where the contracted-out management scored significantly higher than for In-house management. For the other six variables: 'Qualified nursing staff'(Q.6); 'Recruitment of qualified National manpower' (Q.8); 'Staff participate in decision making' (Q.9), 'Experience exchange with other hospitals' (Q.10), 'Saudi staff use high-tech equipment' (Q.11) and 'Management conferences attendance' (Q.12), all scored lower than the accepted mean for both systems, which gives support to Hypothesis One.

Though when the t-value was estimated in order to compare both hospital management styles it was found that three variables, 'Job description', 'Staff participation in decision making' and 'Saudi staff use high tech equipment', the Self-management system was found to be better, but 'Rapid service in emergency cases' was better in the contracted-out system. However, these do not weaken support for Hypothesis One, which is based on overall performance.

For hospitals to run efficiently, the organising ability of the management must be of a high standard for all aspects of hospital elements. From the tabled results, it appears that the hospital staffs need to be better organised in some respects. For example, from the point of view of the patients and the staff, all nurses should be qualified, aware of what their colleagues do in other hospitals in terms of responsibilities, appropriateness of certain techniques and advancement in their field. Personnel should be organised in ways in which Saudis should get the necessary experience and

expertise to perform similar tasks to non-Saudis and, as the government progresses with its Saudisation programmes, be competent to take over such roles.

6.2.4 Directing variables

The 12 management directing variables taken into consideration when assessing the ability of both management systems to direct activities is shown in Table 6.12 percentage assessment of 'Always', the differences between contracted and self-managed hospitals was higher in the case of Hospital Cleanliness for Contracted-out than for Self-managed (19% higher). For consideration of Patients' Complaints (Q, 11% higher for Job Promotion, 10% higher and Attendance at Management Conferences was 8% higher. Self-management scored 6% higher than contracted-out for Cost Awareness and 5% for Medical communication technology. Otherwise there was 4% or less the difference between both management systems.

When the results of 'Always' and 'Mostly' are combined cost awareness for self-managed hospitals shows an appreciable difference, i.e. 21% better than contracted-out. Self-managed being the most cost aware possible reason for this could be that there is more chance of Cost Control over spending in Self-managed than in contracted hospitals where there are several Contractors in charge of separate facilities, unlike the Self-managed where a hierarchical structure of control is topped by one person, (Pincock, 1998). Hospital Cleanliness (Q.1); appears to be better in contracted-out management hospitals, 12% higher. However, as described in chapter 3 in self-managed hospitals the cleaning facilities are often contracted-out. Patients' complaints in contracted-out hospitals are taken into consideration 11% more than in the self-managed system. The reason for this is not clear but probably could be due to the fact that it is easier to force the contractors to compel their workers to improve or

rectify conditions than if Self-managed hospitals (Saudis) are directing non-nationals (Hickson and Pugh, 1995; see Chapter 4). Job promotions were 8% higher for contracted-out, for which the only explanation seems to be that contractors have more rapid turn over of staff (see Chapter 2) than self-managed. All other variables using combined 'Always' and 'Mostly' assessments show differences of < 4%.

When examining the results of responses to directing variables displayed in Table 6.13, it can be seen that out of the 12 variables tested the same five, 'The hospital is clean'; 'Cost awareness'; 'Patients' complaints are considered'; 'Right decision in a reasonable time' and 'Pays attention to complaints and suggestions', showed significantly higher figures than the mean for both hospital systems.

There was no significant difference shown between both systems for the remaining seven, whose results fall below the true mean: 'The hospital takes advantage of medical communication technology'; 'Staff participation in decision making'; 'Speciality conference attendance'; 'Saudi staff use high tech equipment'; 'Management conference attendance'; 'Job promotion' and 'Staff performance rewards'. The results support the contention of Hypothesis One that there is no significant difference in management efficiency and effectiveness between both management systems.

Table 6.12: Analysis of directing variables (by percentage)

No.	Directing Variables	Management style	AL	MO	SO	SE	NE	MI
1	Cost awareness	Contracted Management	191 52%	103 2%	54 15%	16 4%	4 1%	5
		Self- managed	194 58%	90 27%	33 10%	12 3%	7 2%	7
2	Right decision in a reasonable time	Contracted Management	126 34%	132 36%	80 22%	18 5%	13 4%	4
		Self- managed	103 30%	141 42%	60 18%	24 7%	13 4%	3
3	Staff performance rewards	Contracted Management	40 11%	75 20%	76 20%	59 16%	121* 33%	2
		Self- managed	36 11%	72 21%	80 24%	59 17%	91 27%	5
4	Job promotions	Contracted Management	72 20%	63 17%	59 16%	39 11%	129* 36%	11
		Self- managed	36 10%	72 21%	80 24%	59 18%	91 27%	5
5	Saudi staff use high tech equipment	Contracted Management	71 20%	78 21%	73 20%	49 13%	94 26%	8
		Self- managed	71 21%	104 30%	81 24%	31 9%	55 16%	1
6	Staff participate in decision making	Contracted Management	62 17%	102 27%	97 26%	45 12%	65 18%	2
		Self- managed	47 14%	132 39%	97 28%	32 9%	34 10%	1
7	Pay attention to complaints and suggestions	Contracted Management	150 40%	85 23%	50 13%	37 10%	51 14%	0
		Self- managed	152 44%	70 20%	55 16%	40 12%	25 7%	1
8	Management conference attendance	Contracted Management	64 17%	83 22%	69 19%	42 11%	114 31%	1
		Self- managed	31 9%	88 26%	77 22%	48 14%	97 28%	2
9	Speciality conferences	Contracted Management	66 18%	87 23%	90 24%	41 11%	86 23%	3
		Self- managed	54 16%	78 23%	88 26%	58 17%	63 18%	2
10	Patients' complaints are considered	Contracted Management	182 49%	102 27%	47 13%	17 5%	24 6%	1
		Self- managed	129 38%	94 27%	72 21%	23 7%	23 7%	2
11	Medical communication technology	Contracted Management	75 20%	85 23%	93 25%	63 17%	53 5%	4
		Self- managed	52 15%	122 36%	80 23%	43 13%	43 13%	3
12	The hospital is clean.	Contracted Management	218 59%	104 28%	30 8%	11 3%	6 2%	4
		Self- managed	138 40%	199 35%	61 18%	10 3%	12 4%	3

AL: Always, MO: Mostly, SO: sometime, SE: Seldom, NE: Never, and MI: Missing response.

Even though, when the t-test was applied (see Table 6.13) in order to test which is the better of both systems, even where their scores are either higher or lower than the accepted mean. The Contracted-out system proved better than the Self-management for hospital cleanliness (Q.1), whereas the reverse was true for 'Pays attention to complaints and suggestions' (Q.3), 'Participation in decision making' (Q.7), 'Staff attendance at speciality conferences'(Q.8), and 'Saudi staff use high tech equipment'(Q.9). However, this does not refute Hypothesis One, which is based on overall variables performance.

Table 6.13: Analysis of directing variables

No.	Directing Variables	Contracted Management		Self-Management		Significance difference
		Mean	Z	Mean	Z	t-value
1-	The hospital is clean.	4.40	19.65*	4.06	10.22*	-4.788
2-	Cost awareness	4.25	15.30*	4.35	16.57*	1.410
3-	Patients' complaints attended	4.08	9.56*	3.83	5.08*	-2.815
4-	Right decision in a reasonable time	3.92	7.80*	3.87	6.56*	-0.635
5-	Pays attention to staff's complaints and suggestions	3.66	2.16*	3.83	4.6*	1.653
6-	The hospital uses medical communication technology	3.18	-4.62	3.29	-3.12	1.136
7-	Staff participate in decision making	3.14	-5.25	3.37	-2.11	2.480
8-	Specialty conference attendance	3.02	-6.50	3.01	-6.8	3.398
9-	Saudi staff use high-tech equipment	2.95	-7.15	3.31	-2.64	3.407
10-	Management conference attendance	2.84	-8.50	2.73	-10.53	-1.030
11-	Job promotion	2.75	-9.15	2.71	-10.75	-0.362
12-	Staff performance rewards	2.61	-12.24	2.73	-10.76	-1.173
Over all Mean		3.40		3.42		
t- value= -0.0993		df = 22,				**p – value =0.9218

* Significant at level (0.05), where Z- value >1.65, level of confidence (0.95).
** Significant at level (0.05), where p- value < .05, level of confidence (0.95).
H0: Mean < 3.5
H1: Mean > 3.5

The results that fall below the true mean for certain variables involved in directing hospital affairs imply that more attention is needed to these variables. In order for a hospital to keep abreast with advances in medicine and new technology then the staff should be made aware of them and given the opportunity to meet, at conferences,

others involved in the same field of both experience and research. Medicines and surgery methods are in a stage of constant upgrading and development, and, what cannot be overlooked, methods employed in the past have either been found to be inefficient or even unsatisfactory in the long term. If the Saudi Government's intention to increase the number of nationals (see Chapter 3) employed in specialised jobs, then the hospital management needs to direct its attention to providing the opportunity for its fellow countrymen to be employed in skilled jobs and the use of high-tech equipment. If such employees are involved in the decision-making process for their field of expertise, the, inevitably, they will value their tasks.

6.2.5 Controlling variables

Table 6.14 gives the number of respondents to the questionnaires out of a total of 373 for contracted-out and 343 for self-management. When comparing both systems, Table 6.14 shows that Contracted-out is 12% higher for Total Quality Management's effectivity than for Self-managed; 11% for Consideration of Patients' complaints; 9% for Nutrition services; 8% for satisfaction for the skills of medical staff; 7% concern for Qualifications when recruiting staff and 6% for Quality control of medical care. For the remaining variables there is less than a 5% difference between the two management systems.

Table 6.14: Analysis of controlling variables (by percentage)

No.	Controlling Variables	Management Style	AL	MO	SO	SE	NE	MI
1	Saudi staffs use high tech equipment.	Contracted	71 20%	78 21%	73 20%	49 13%	94 26%	8
		Self-management	71 21%	104 30%	81 24%	31 9%	55 16%	1
2	Staff reliability	Contracted	242 65%	93 25%	26 7%	5 1%	6 2%	1
		Self-management	239 70%	56 16%	27 .8%	10 3%	9 3%	2
3	Staff's performance evaluation	Contracted	113 30%	102 28%	49 13%	51 14%	57 15%	1
		Self-management	107 31%	107 31%	49 14%	37 11%	42 12%	1
4	Performance improvement	Contracted	112 30%	97 26%	76 20%	46 12%	41 11%	1
		Self-management	109 32%	114 33%	59 17%	25 7%	35 10%	1
5	Quality improvement systems	Contracted	106 28%	114 31%	77 21%	32 9%	43 11%	1
		Self-management	93 27%	104 31%	93 27%	25 7%	27 8%	1
6	Quality control of medical care	Contracted	124 34%	108 30%	70 19%	20 5%	45 12%	6
		Self-management	95 28%	119 35%	65 19%	16 5%	45 13%	3
7	Accuracy of laboratory results	Contracted	87 23%	165 44%	85 23%	20 6%	13 4%	3
		Self-management	82 24%	163 48%	70 20%	10 3%	16 5%	2
8	Medical staff skills are satisfactory	Contracted	89 24%	160 44%	83 23%	22 6%	12 3%	7
		Self-management	55 16%	170 50%	87 25%	15 5%	14 4%	2
9	Qualifications matter of staff recruitment	Contracted	95 26%	118 32%	71 19%	46 13%	39 10%	4
		Self-management	64 19%	122 36%	97 28%	26 8%	31 9%	3
10	Nutrition services	Contracted	72 20%	135 37%	75 21%	40 10%	44 12	7
		Self-management	38 11%	139 41%	91 27%	31 9%	39 12%	5
11	Patients' complaints attended	Contracted	182 49%	102 27%	47 13%	17 5%	24 6%	1
		Self-management	129 38%	94 27%	72 21%	23 7%	23 7%	2
12	Total Quality Management implemented	Contracted	93 25%	90 25%	96 26%	40 11%	48 13%	6
		Self-management	44 13%	87 25%	109 32%	52 15%	50 15%	1

AL: Always, MO: Mostly, SO: sometimes, SE: Seldom, NE: Never, MI: Missing response.

To test the percentages significant difference to the results lend further support to the hypothesis that there is no difference in performance of the management variables.

The data was analysed is by mean, Z and t-values of the 12 controlling variables as shown in Table 6.15, to which responses were sought. Four: 'Staff reliability'; 'Patients' complaints attended'; 'Skills of medical staff' and 'Accuracy of laboratory results' were significantly higher than the true mean for both hospital systems. Whereas 'Performance improvement'; 'Qualifications matter for recruitment'; 'Staff's performance evaluation'; 'Nutrition services'; 'Total Quality Management' and 'Saudi staff use high tech equipment' gave results below the true mean for both hospital systems. 'Quality control for medical care' was significantly higher for Contracted-out management than for Self-management, whereas 'Performance improvement' was higher for Self-management.

The responses to the controlling aspect of hospital management reveal that of both systems, when taking all the variables into consideration, so as to obtain an overall assessment, neither of the two emerges as preferable. Therefore, the controlling variables aspect of hospital management supports the Hypothesis One.

When the t-value test was applied the results of two variables: 'Patients complaints attended' and 'Total Quality Management implemented' were significantly better for Contracted-out management, whereas for 'Performance improvements' and 'Saudi staff use high-tech equipment' scored better for the Self-management. This finding does not contradict Hypothesis One.

When inspection is made of the variable to whom responses were below the true mean, it can be seen that both hospitals are under-performing in vital areas, e.g. improving hospital facilities, recruiting staff according to their qualifications, and

once they are employed making sure that their performance is monitored. The nutrition services, also, show that it could be improved. The attendance of the present hospital management, of both hospital systems, needs to be drawn to these deficiencies in management control.

Table 6.15: Analysis of controlling variables

No.	Controlling Variables	Contracted Management		Self-Management		Significance difference
		Mean	Z	Mean	Z	t-value
1-	Staff reliability	4.51	23.75*	4.48	19.05*	-0.452
2-	Patients' complaints attended	4.08	9.56*	3.83	5.08*	-2.815
3-	Skills of medical staff	3.80	5.85*	3.70	3.97*	-1.390
4-	Accuracy of Laboratory results	3.79	5.69*	3.84	6.40*	0.680
5-	Quality control of medical care	3.67	2.47*	3.60	1.42	-0.710
6-	Quality improvement systems	3.56	0.89	3.62	1.88*	0.644
7-	Performance improvements	3.52	0.29	3.69	2.77*	1.743
8-	Qualifications matter for recruitment	3.50	0.0	3.48	-0.32	-0.217
9-	Staff's performance evaluation	3.44	-0.86	3.58	1.10	1.342
10-	Nutrition services	3.41	-1.06	3.31	-3.04	-0.937
11-	Total Quality Management implemented	3.38	-1.74	3.07	-6.46	-3.229
12-	Saudi staff use high tech equipment	2.95	-7.15	3.31	-2.64	3.407
	Over all Mean	3.63		3.63		
t- value= - 0.055		df = 22,		**p – value =0.9567		

* Significant at level (0.05), where Z- value >1.65, level of confidence (0.95).
** Significant at level (0.05), where p- value < .05, level of confidence (0.95).
H0: Mean < 3.5
H1: Mean > 3.5

6.2.6 Employees' satisfaction variables

From the respondents' assessments to the satisfaction variables shown by percentage estimation in Table 6.16 when comparing contracted-out with self-managed the largest percentage difference for 'Always' is 13% higher for clarity of work procedures in Contracted-out management; Job Promotions are 10% higher and Attendance at Management Conferences are 8% higher for this system. Self-managed hospital management scores higher 9% for staff participation in decision-making.

Table 6.16: Analysis of satisfaction variables (by percentage)

No.	Satisfaction variables	Management Style	AL	MO	SO	SE	NE	MI
1	Department objectives are clear	Contracted	203 54%	110 30%	38 10%	17 5%	5 1%	0
		Self-managed	184 54%	111 33%	25 7%	5 1%	15 2%	3
2	Work procedures are clear	Contracted	177 48%	132 35%	41 11%	17 5%	5 1%	1
		Self-managed	120 35%	157 46%	36 10%	14 4%	16 5%	0
3	Make suitable decision in time	Contracted	126 34%	132 35%	180 21%	18 5%	13 4%	4
		Self-managed	102 30%	141 42%	60 18%	24 7%	13 4%	3
4	Pays attention to complaints and suggestions	Contracted	150 40%	85 23%	50 13%	37 10%	51 14%	0
		Self-managed	152 44%	70 20%	55 16%	40 12%	25 7%	1
5	Equipment maintenance satisfactory	Contracted	96 26%	128 34%	81 22%	33 9%	32 9%	3
		Self-managed	58 17%	149 44%	80 23%	28 8%	26 7%	2
6	Staff participate in decision making	Contracted	62 17%	102 27%	97 26%	45 12%	65 17%	2
		Self-managed	47 14%	132 39%	97 28%	32 9%	34 10%	1
7	Jobs are stable in this institution	Contracted	83 23%	87 24%	67 18%	28 8%	102 27%	6
		Self-managed	58 17%	118 35%	74 22%	28 8%	63 18%	2
8	Speciality conference attendance	Contracted	66 18%	87 24%	90 24%	41 11%	86 23%	3
		Self-managed	54 16%	78 23%	88 26%	58 17%	63 18%	2
9	Management conference attendance	Contracted	64 17%	83 22%	69 19%	42 11%	114 31%	1
		Self-managed	31 9%	88 26%	77 23%	48 14%	97 28%	2
10	Job promotion possible	Contracted	72 20%	63 17%	59 16%	39 11%	129 36%	11
		Self-managed	36 10%	72 21%	80 24%	59 18%	91 27%	5
11	Staff performance rewards	Contracted	40 11%	75 20%	76 20%	59 16%	121 33%	2
		Self-managed	40 12%	56 16%	99 29%	61 18%	84 25%	3
12	Retirement scheme	Contracted	53 15%	46 13%	34 10%	34 10%	181 52%	25
		Self-managed	31 10%	75 23%	47 14%	30 09%	143 44%	17

AL; Always, MO: Mostly, SO: sometime, SE: Seldom, NE: Never, and MI: Missing response.

Otherwise, the differences for this system are less than 4% higher for the remaining variables.

When analysis of the responses to the Satisfaction variables by use of the mean, Z and t-values are shown on Table 6.17. From the results displayed it can be seen that of the 12 variables four, i.e. 'Departmental objectives are clear', 'Work procedures are clear'; 'Make suitable decisions in time' and 'Notes complaints and suggestions', have responses above the true mean for both hospital systems. Of the remaining eight, i.e. 'Equipment maintenance satisfactory'; 'Staff participate in decision making'; 'Jobs are stable in this institution'; 'Speciality conference attendance'; 'Management conference attendance'; 'Job promotion possible'; 'Staff performance rewards' and 'Hospital retirement scheme', neither hospital system has results above the true mean. Therefore, these results support Hypothesis One.

However, Table 6.17 on close inspection of the levels of satisfaction expressed for the variables to which responses are below the true mean, some disquiet should be felt. Both contracted-out and in-house management's attention, if they hope to run an efficient establishment manned by satisfied workers, must be drawn to these variables, e.g. 'satisfactory' equipment is vital, in particular in life and death situations. Worker satisfaction is equally important as no hospital can be efficient if the staff feel that they have few prospects for promotion, rewards for outstanding performance and the assurance that theirs is 'a job for life' and that when they retire their future needs will be provided for by a retirement scheme. The only significance difference for contracting-out is for work procedures could be more clearer than in-house management where t-value > -1.65, but two variables by in-house management

such as wages and for staff's participation in decision making are more significantly better than in contracted-out management where t-value > 1.65.

Table 6.17: Analysis of satisfaction variables

No.	Satisfaction Variables	Contracted Management		In-house Management		Significance difference
		Mean	Z	Mean	Z	t-value
1-	Department objectives are clear	4.31	17.00*	4.29	14.2*	-0.275
2-	Work procedures are clear	4.23	15.30*	4.02	9.43*	-2.894
3-	Make suitable decisions in time	3.92	7.80*	3.87	6.45*	-0.643
4-	Pays attention to complaints and suggestions	3.66	2.16*	3.83	4.63*	1.653
5-	Equipment maintenance Satisfactory	3.60	1.59	3.54	0.74	-0.690
6-	Staff participate in decision making	3.14	-5.18	3.37	-2.03	2.467
7-	Jobs are stable in this institution	3.06	-5.51	3.23	-3.70	1.568
8-	Specialty conference attendance	3.02	-6.55	3.01	-6.84	-0.097
9-	Management conference attendance	2.84	-8.54	2.73	-7.70	-1.040
10-	Job promotion possible Staff performance rewards	2.75	-9.15	2.71	-10.66	-0.362
11-	Hospital retirement scheme	2.61	-12.10	2.73	-10.73	1.167
12-		2.30	-14.35	2.45	-12.82	1.283
Overall Mean		3.30		3.32		
t-value = -0.1109		df = 22,		**p – value =0.9127		

* Significant at level (0.05), where Z- value >1.65, level of confidence (0.95).
** Significant at level (0.05), where p- value < .05, level of confidence (0.95).
H0: Mean < 3.5
H1: Mean > 3.5

When assessing, by means of the t-values, which assesses hospital performs best, out of the 12 variables, 'Work procedures are clear' was better in Contracted-out management and/or two variables, 'Pays attention to complaints and suggestions' and 'Staff participation in decision making', the Self-managed scored higher. These results do not negate Hypothesis One, which is concerned with overall performance.

6.3 Analysis relating to Hypothesis Two

The hospitals staff's response to questions Q.41, Q.42 and Q.43 of the set Questionnaire, regarding various categories of hospital management staff in

contracted-out and in-house managed hospitals in order to determine whether they consider which type of management is preferable for public hospital management services and for what type of service: (for only non-medical or medical, or for all services as well).

Three questions from the Questionnaire list were put to respondents to examine their point of view regarding which hospital services are better managed by contracted-out management rather than in-house management. The responses was analysed according to their Job position on the hospital staff, their Level of Education, and their Nationality. The Questions were:

Q.41 Contracted management is better than Self-managed for managing of all hospital services, *apart from medical service.*

Q.42 Contracted rather than Self-managed is better for managing the hospital *medical services.*

Q.43 Contracted rather than Self-managed is better for managing *all hospital services.*

The results were analysed by assessing their mean and determining the Z-value for their significance. The mean is taken as 3.0 and the Z- value at 1.65.

6.3.1 Positions held by respondents to Q.41

After testing whether the positions (Director / Manager, non-medical staff, and medical staff) occupied by respondents in the contracted-out hospitals influenced their choice of answer the results were tabulated on Table 6.18. They show that the respondent's position was not significant in determining whether they believed that contracted-out management is better for managing all the public hospitals services

apart from medical services. Table 6.18 displays the responses to five possible estimations of determining whether contracted-out management for all services other than medical is the best method for managing Public hospitals.

Table 6.18: Positions of respondents to Q.41

Q.41. Contracted management rather than in-house managed is better for managing all hospital services, *apart from medical service.*						
Hospitals Staff	Always (5)	Mostly (4)	Sometimes (3)	Seldom (2)	Never (1)	Total
Contracted-out Management Respondents						
Directors / Managers	33	10	29	31	36	139
Mean =2.81			Z – value = -1.52			
Non-medical Staff	18	05	25	18	17	83
Mean = 2.87			Z – value = -0.86			
Medical staff	39	11	41	33	20	134
Mean = 3.11			Z – value = 0.92			
In-house Managed Hospitals Respondents						
Directors / Managers	12	10	34	40	22	118
Mean = 2.58			Z – value = -3.88			
Non-medical Staff	12	06	15	14	12	59
Mean = 2.86			Z – value = -0.74			
Medical staff	33	17	43	40	31	164
Mean = 2.88			Z – value = -1.07			

Testing for the level of Confidence = 0.95 , which has Z- tabulated = 1.65
H0: $M < 3$
H1: $M > 3$

The Directors / managers responses had a Z-value = -1.52 which shows that contracting-out management was not significantly better in their evaluation, than in-house management hospitals. The non-medical Staff and the Medical staff's responses gave Z-values = (-0.86 and 0.92), which means that their opinions were similar to those of the Director/ Managers which means that contracted management was not any better than in-house management.

Therefore the position that a person holds in the hospital did not affect his/her response to this question. That the staff of contracted-management hospitals did not consider that contracted management was better than in-house managed hospital for all services apart from medical, could be due to any or all of the following reasons: the train of management is not clear because of the variety of contractors employed in each hospital and their short term contracts (three years), which has a detrimental effects on the staff continuity; promotional prospects were poor, due to same staff being engaged solely for a specific task and there is, in this case, a lack of a teamwork spirit (Al-Oraij, 1998). Other possible reasons include: contracted-out management is often more costly than in-house management due to them needing to make a profit; the money used to employ a private contractor over and above what is required for self- management could be invested for patients' care. With in-house management there would be more freedom to negotiate and deal directly with sub-contractors and maybe employ more qualified technical staff (Al-Abdul Jabar, 1997; Al-Oraij, 1998; Al-Thumaly, 1998).

When assessing the responses to the same question from similar staff in in-house managed hospitals, their responses agreed with those from contracted-out hospital management i.e. they did not consider contracted-out to be significantly better than in-

house managed hospitals. The Z-values obtained were = –3.88, -0.74 and –1.07 respectively.

6.3.2 Educational attainment of respondents to Q.41

The same question (Q.41) was put to hospitals staff of different level of education attainment in contracted-out managed hospitals to see whether this has an effect on their response. Table 6.19 shows the calculated Z-values obtained were = -0.85, -1.72 and 0.40 respectively which was below the accepted level of the significant level of 1.65. Therefore, contracted-out management in this case was not considered to be significantly better regardless of the educational attainment of the respondents. At the level of Confidence = 0.95 , which has Z- tabulated = 1.65

When the responses given by staff of different educational attainment in Self-managed hospitals were assessed it was discovered that has a different level of education did not mean having a different response to the question. The Z-values for those with Higher Degrees was = –1.52, First Degrees = -1.61 and for a Lower education Z- value = –2.03. So there was no preference result for all hospitals' staff's choice of hospital non-medical services provided contracted-out management system

Table 6.19: Educational attainment

Q.41. Contracted management rather than Self-managed is better for managing all hospital services, *apart from Medical service.*						
Hospitals Staff	Always (5)	Mostly (4)	Sometimes (3)	Seldom (2)	Never (1)	Total
Contracted-out hospitals management Respondents						
Higher Degree	17	06	12	19	17	65
	Mean = 2.98		Z – value = -0.85			
First degree	38	15	44	44	40	181
	Mean = 2.81		Z – value = -1.72			
No degree	30	04	30	16	21	101
	Mean = 3.06		Z – value = 0.40			
Self- Managed Hospitals Respondents						
Higher Degree	17	11	33	33	16	110
	Mean = 2.82		Z – value = -1.52			
First degree	21	10	30	37	19	117
	Mean = 2.80		Z – value = -1.61			
No degree	19	12	27	24	28	110
	Mean = 2.73		Z – value = -2.03			

H0: M < 3
H1: M > 3

The lack of support for contracted-out management given by hospital staff of both types of management is possibly for similar reasons given by staff employed in different positions in in-house managed hospitals. Also, the fact that contracted-out management does not compensate for the lack of job security by paying any better

than hospitals run by the Ministry of Health. Qualified staff, in particular, are engaged by Contractors for a specific period (as mentioned above), so not only do they lack the chance of promotion, but also it can mean having a variety of staff in higher positions in control of them whose contracts do not operate consecutively with their own, which can be disruptive and impede job satisfaction.

6.3.3 Nationality of respondents to Q.41

Taking into consideration the nationality of respondents, it was found that between Saudis and non-Saudis there was no significant difference in support for contracted-out management in all hospitals services, apart from medical in both types of management. In hospitals of contracted-out management, Table 6.20 shows Saudis have a Z-value = -1.02 and non-Saudis Z-value = -.018. In the in-house managed hospitals staff for the Saudis Z- values = -2.83 and for non-Saudis Z- values = -1.48. therefore, the results are not significant.

The nationality (Saudi and non-Saudi) of respondents, also showed no significant support for Self-managed hospital to manage all hospital services apart from medical services, Z- values = -2.83 and -1.48 respectively. Possible reasons could be that, at present, the Contracted-out management system, is not satisfying its staff: some Contracted-out managements have delayed paying some hospital staff wages.

Table 6.20: Nationality of respondents to Q.41

Q.41. Contracted management rather than in-house managed is better for managing all hospital services, *apart from medical service.*						
Hospitals Staff	Always (5)	Mostly (4)	Sometimes (3)	Seldom (2)	Never (1)	Total
Contracted-out Hospital Management						
Saudi	33	07	33	42	24	139
Mean = 2.88			Z – value = -1.02			
Non-Saudi	57	19	61	41	48	226
Mean = 2.98			Z – value = -0.18			
In-house Managed Hospitals Respondents						
Saudi	34	21	48	54	45	202
Mean = 2.73			Z – value = -2.83			
Non-Saudi	23	12	44	40	20	139
Mean = 2.84			Z – value = -1.48			

H0: M < 3
H1: M > 3
The level of Confidence = 0.95 , which has Z- tabulated = 1.65

6.3.4 Positions of respondents to Q.42

Table 6.21 shows responses to the statement regarding whether Contracted-out management is better than in-house management for medical services. Of the respondents employed in contracted-out management, the Directors / Managers and non-medical staff considered that contracting-out management was not significantly better for this purpose as the. Z- values were = -0.83 and 2.58 respectively. However, Medical Staff did believe that contracted-out hospital medical services were better in their opinion of the best system of management for them than was in-house managed.

Their results gave a Z- value = 2.58 which is a significant response. The reasons for this latter choice are not immediately obvious. It is highly possible that even without a strong possibility of promotion within their field they could, before re-engagement, negotiate a better salary from the contractors. Another reason could be that as they have transferable skills. This means that they are not tied to a particular contractor for more than the period of the contract, so if dissatisfied with the working conditions i.e. organisational culture, they are free to leave to join another firm of contractors.

However, medical staff of in-house managed hospitals when assessing whether the private/contracted sector was better for managing public hospitals medical services (see Table 6.21) did not consider that contracted-out management was significantly better than self-management. The Z- values = -2.60, 0.37 and 0.88 respectively which are not significant in determining the true value of the result.

It seems strange that they had a different view to those of staff of similar status in contracted-out hospitals. The reasons for these views are not determined by their system of hospital management.

Table 6.21: Positions of respondents to Q.42

Q.42. Contracted management rather than in-house managed is better for managing the *medical services*.						
Staff' Position	Always (5)	Mostly (4)	Sometimes (3)	Seldom (2)	Never (1)	Total
Contracted-out Hospital Management						
Directors / Managers	35	16	24	29	36	140
	Mean = 2.89		Z– value = -0.83			
Non- Medical Staff	23	10	14	23	15	85
	Mean = 2.87		Z – value = -0.82			
Medical staff	42	19	36	33	14	144
	Mean = 3.29		Z – value = 2.58			
In-house Hospital Management						
Directors / Managers	12	13	43	32	19	119
	Mean = 2.72		Z – value = -2.60			
Non- Medical Staff	13	10	15	10	11	59
	Mean = 3.07		Z – value = 0.37			
Medical staff	42	21	38	39	25	165
	Mean = 3.10		Z – value = 0.88			

H0: M < 3
H1: M > 3
At the level of Confidence = 0.95 , which has Z- tabulated = 1.65

6.3.5 Education of respondents to Q.42

The education attainment of respondents was taken into consideration for Q42, shown on Table 6.22. It was found that those with Higher Degrees, or First Degree and for those of only Secondary education or less, none considered that Contracting-out management was significantly better than Self-management of public hospitals

management. Z- values were 0.42, -0.52, and 1.60 respectively for Contracted-out management hospitals, and for that for Self-managed hospitals Z-values were 0.30, 0.88 and –1.61 respectively. All Z-values are below significant level of 1.65.

Table 6.22: Education of respondents to Q.42

Q.42. Contracted management rather than in-house managed is better for managing the *medical services.*						
Education attainment	Always (5)	Mostly (4)	Sometimes (3)	Seldom (2)	Never (1)	Total
Contracted-out management						
Higher Degree	19	05	12	20	09	65
Mean = 3.08			Z – value = 0.42			
First degree	42	20	40	46	34	182
Mean = 2.95			Z – value = -0.52			
No degree	33	17	15	16	21	102
Mean = 3.25			Z – value = 1.60			
In-house management Hospitals						
Higher Degree	21	15	33	29	12	110
Mean = 3.04			Z – value = 0.30			
First degree	27	16	35	21	18	117
Mean = 3.11			Z – value = 0.88			
No degree	19	13	28	30	22	112
Mean = 2.80			Z – value = -1.61			

H0: $M < 3$
H1: $M > 3$
At the level of Confidence = 0.95 , which has Z- tabulated = 1.65

It can be deduced that respondents employed by Contracted-out management are not fully supportive of their present management system. Similarly respondents in Self-managed hospitals did not consider Contracted-out management to be better for medical services. Again this could reflect their satisfaction with their present hospital management rather than whether the management system is Contracted-out or Self-managed, Hannagan, (1995).

6.3.6 Nationality of respondents to Q.42

Table 6.23 shows that Saudis and non-Saudis considered contracted-out management for medical services not significantly better. All the responses made by Saudi and non-Saudi of all public hospitals, of all positions, and at all educational levels, apart from medical staff of the contracted-out hospitals, no significant Z-values.

Table 6.23: Nationality of respondents to Q.42

Q.42. Contracted management rather than in-house managed is better for managing *the medical services.*						
Hospitals Staff	Always (5)	Mostly (4)	Sometimes (3)	Seldom (2)	Never (1)	Total
Contracted-out Public Hospital Management						
Saudi	38	18	22	44	17	139
Mean = 3.12 Z– value = 0.95						
Non-Saudi	63	27	51	41	48	230
Mean = 3.07 Z – value = 0.71						
In-house Management Hospitals						
Saudi	39	27	56	43	38	203
Mean = 2.93 Z– value = -0.72						
Non-Saudi	28	17	40	38	17	140

Mean = 3.01	Z – value = 0.07

H0: M < 3
H1: M > 3
The level of Confidence = 0.95 , which has Z- tabulated = 1.65

6.3.7 Positions of respondents to Q.43

To Q.43 in Table 6.24 whether contracted sector is better than the in-house managed sector to manage all services efficiently, the respondents gave the following responses. The Directors / managers and non-medical staff of the contracted-out management sector did not consider that contracted-out management was significantly better than in-house managed hospitals. Z-values: -0.39 and –0.81, respectively, were obtained. However, the opinions of Medical staff showed a significant Z-value = 2.46. This is understandable in view of their answer to Q.42 (Table 6.21) where they were in favour of contracted-out management for medical services (Z- value = 2.58).

In response to the statement concerning whether the contracted-out management is better than the Self-managed sector to manage all hospital services, the opinions of in-house managed hospitals staff including medical staff are shown in Table 6.24. Z-values were -3.79, 1.10 and 1.17 respectively. This is interpreted that they do not consider Contracted-out management to be significantly better for all services.

Table 6.24: Positions of respondents to Q.43

Q.43. Contracted management rather than in-house managed is better for managing all hospital services.						
Positions	Always (5)	Mostly (4)	Sometimes (3)	Seldom (2)	Never (1)	Total
Contracted-out Hospital Management						
Directors / Managers	37	14	28	27	34	140
Mean = 2.95			Z – value = -0.39			
Non-medical Staff	19	11	13	24	18	84
Mean = 2.87			Z – value = -0.81			
Medical staff	46	16	35	30	18	145
Mean = 3.29			Z – value = 2.46			
In-house Management Hospital Respondents						
Directors / Managers	12	07	41	40	19	119
Mean = 2.61			**Z – value = -3.79**			
Non-medical Staff	13	10	18	11	07	59
Mean = 3.19			Z – value = 1.10			
Medical staff	41	24	39	37	24	165
Mean = 3.13			Z – value = 1.17			

H0: $M < 3$
H1: $M > 3$
At the level of Confidence = 0.95 , which has Z- tabulated = 1.65

6.3.8 Educational attainment of respondents to Q.43

Table 6.25 shows responses analysed according to the respondents' education level, regarding whether Contracted-out or Self-management is better for all hospital services. The table shows that respondents holding higher and first degrees expressed

no significant preference (Z- values = -0.09 and –0.82 respectively). This latter could be because, in most cases, Contracted-out management pay better for unqualified staff than do Self-managed hospitals.

Table 6.25: Educational attainment of respondents to Q.43

Q.43. Contracted management rather than in-house managed is better for managing *all hospital services.*						
Hospitals Staff	Always (5)	Mostly (4)	Sometimes (3)	Seldom (2)	Never (1)	Total
Contracted-out Hospital Management						
Higher Degree	16	06	13	21	09	65
Mean = 2.98			Z– value = -0.09			
First degree	44	21	34	42	42	183
Mean = 2.91			Z– value = -0.82			
No degree	35	13	21	15	18	102
Mean = 3.31			Z – value = 2.10			
In-house Management Hospital Respondents						
Higher Degree	20	14	35	30	11	110
Mean = 3.02			Z – value = 0.15			
First degree	27	14	31	28	17	117
Mean = 3.05			Z – value = 0.40			
No degree	19	13	31	30	19	112
Mean = 2.85			Z– value = -1.22			

H0: $M < 3$
H1: $M > 3$
At the level of Confidence = 0.95 , which has Z- tabulated = 1.65

6.3.9 Nationality of respondents to Q.43

When taking the nationality of all the respondents into consideration, both Saudis and non-Saudi's in the contracted-out management and in-house managed of all hospitals respondents considered the contracted-out management sector was not significantly better than the in-house managed sector for managing and operating all hospital medical and non-medical services. In Table 6.26, Saudi nationals of the contracted-out hospitals have Z-= value = 0.58 and the non-Saudi Z- values = 1.15

Table 6.26: Nationality of respondents to Q.43

Q.43. Contracted management rather than in-house managed is better for managing *all hospital services.*						
Hospitals Staff	Always (5)	Mostly (4)	Sometimes (3)	Seldom (2)	Never (1)	Total
Contracted-out Hospital Management						
Saudi	38	12	26	39	24	139
Mean = 3.01			Z – value = 0.58			
Non-Saudi	65	29	49	41	46	230
Mean = 3.11			Z – value = 1.15			
In-house Management Hospital Respondents						
Saudi	41	22	57	47	36	203
Mean = 2.93			Z – value = -0.77			
Non-Saudi	25	19	41	41	14	140
Mean = 3.0			Z– value = 0.0			

H0: M < 3
H1: M > 3
The level of Confidence = 0.95 , which has Z- tabulated = 1.65

While this result is understandable for Saudis if the loyalty factor is taken into consideration i.e. Saudi favouring self-managed where there is a possibility of the director being Saudi or likely to be Saudi in the near future, in line with the government Saudisation programme, for non-Saudis the reason has to be sought elsewhere. Non-Saudis possibly feel more confident about job stability in self-managed public hospitals than in hospitals in which the management is contracted-out, and in which contractors can change as the contracts are only for short term i.e. three years.

Similarly, when considering respondents in the in-house managed sector, the Saudi results showed no significance Z- values = -0.77 and also, for the non-Saudi respondents considered that contracted was not significantly better Z- value = 0.0, (see Table 6.26).

Overall, the answers given by respondent in both management systems show when tested for significance, that they do not consider contracted-out management to be better than self-managed. This conclusion supports the research hypotheses stated in chapter one: that all public hospitals staff would rather have self-managed public hospitals more than contracted-out hospital management.

6.4 Summary

The five aspects of both public and private management: planning, organising, directing, controlling and staff satisfaction were tested in both hospital management systems under examination by means of the use of Questionnaires which encouraged responses to 12 variables for each aspect. After calculating the percentages obtained end the statistical analyses for each variable, the result accept the null hypothesis for Hypothesis One. However, the following tables (Tables 6.27 - 6.30) show that certain

management variables were determined to be successfully accomplished under both management systems. Other variables that failed to reach the desired standard of the mean score of at least 3.5 could not be considered effective and efficient. Some management variables were more significantly determined by the t-test in one or other management system but not in both.

Table 6.27: Management variables in both management systems which proved effective

No.	Management Variables
1-	Department objectives are clear
2-	Work procedures are clear
3-	Medical staff skills
4-	Saudi staff hold key positions
5-	Skills of medical staff
6-	Accuracy of Laboratory results
7-	Flexibility to simplify work procedure
8-	Job responsibilities are clear
9-	Position requirements are clear
10-	The hospital is clean.
11-	Cost awareness
12-	Patients' complaints attended
13-	Right decision in a reasonable time
14-	Staff's complaints and suggestions attended

When examining the analysis of the questionnaires it was reveals that certain management variables were determined as being successfully accomplished under both management system. These are some effective management variables, which detailed on the following Table 6.27.

Basically, it appears that both types of public hospitals' management have a management who employ skilled reliable staff who are made aware of their job responsibilities, and work in a clean environment, patients complaints are attained and that Saudi employees can attain key positions.

However, both systems, in some respects, fail to reach desired standard. Table 6.28 lists 19 variable where both systems could not be considered effective and efficient.

These are included problems with equipment; lack of job stability, incentives and retirement scheme; the chance for staff to participate in conferences of their speciality, and gain more experience by interchanging knowledge with other hospitals, and what was highly significant for the government's Saudisation programme was that Saudi staff did not have the opportunity to use high technology.

If this is not remedied quickly then it would mean that in this important field reliance would still have to be placed on non-nationals. Although, it appeared that both hospital systems had skilled medical staff.

Table 6.28: Management variables in both management systems which proved ineffective

No.	Management Variables
1-	Equipment maintenance
2-	Hospital increases services
3-	Jobs are stable in this institution
4-	Saudi Technical staff
5-	Hospital retirement scheme
6-	Qualified Nursing staff employed
7-	National human resource development
8-	Experience exchange with other hospitals
9-	The hospital uses medical communication technology
10-	Staff participate in decision making
11-	Specialty conference attendance
12-	Saudi staff use high-tech equipment
13-	Management conference attendance
14-	Job promotion
15-	Staff performance rewards
16-	Qualifications matter for recruitment
17-	Staff's performance evaluation
18-	Nutrition services
19-	Total Quality Management implemented

Table 6.29 detailed six variables that were more significant determined by the t-test in contracted-out hospital's management than in in-house. The evaluation to certain variables; the clarity of work procedures, the availability of using high-technology, and rapid service in emergency cases. These are being better for contracted-out management, can be explained by the fact that contracted-out management normally starts in operating new hospitals, which have new often high-technology equipment

when they take over, whereas in-house management come accumulated in a later time to continue, in some cases, having to use equipment purchased some time ago.

Table 6.29: Management variables that are more significantly effective in contracted-out management than in in-house management

No.	Management Variables
1-	Work procedures are clear
2-	Availability of high-Technology
3-	Rapid service in emergency cases
4-	The hospital is clean
5-	Patients' complaints attended
6-	Total Quality Management implemented

Where management variables significantly better in-house hospitals' management than in contracting-out, Table 6.30. There are six variables such as that staff have more participation to help in making right decision and can have there complaints and suggestions attended. What is highly significant and could be expected is that Saudi staff have a better chance to be employed by in-house management than contracted-out, which means that Saudis are therefore, more likely to receive on the job training or they have better wages, or more stable jobs than in contracted management.

When relating the analysis of both hospitals' management systems, performances, with regards to the set variables to Hypothesis One, it can be seen that it cannot be stated that there is one management is more effective and efficient than the other as most of the variables are just about equally distributed between high and low in both systems. This means that Hypothesis One is accepted.

Table 6.30: Management variables that are more significantly effective in in-house management than in contracted-out management

No.	Management Variables
1-	Pays attention to complaints and suggestions
2-	Staff participate in decision making
3-	Performance improvements
4-	Saudi staff use high tech equipment
5-	Specialty conference attendance
6-	Job description is clear

When testing the validity of Hypothesis Two, that position, education attainment and nationality influence the choice of management system it was found that contracted-out management was not deemed to be better than in-house management in judgement of the respondents from the selected of ten public hospitals, five of which have contracted-out management, and the other five with in-house management (see Tables 6.18 - 6.26), in that there is no significant differences in management effectiveness and efficiency, this also supports Hypothesis One.

When the position in the hospital hierarchy of the respondents to the three statements, which dealt with the management of all hospital services apart from medical (Tables 6.18 - 6.20), medical services (Tables 6.21 - 6.23), and for all services including medical services (Tables 6.24 - 6.26) were taken into consideration, there were only the Medical staff (Tables 6.21 and 6.24) and those below degree status ("no degree") who considered (Table 6.25) showed that contracted-out management was significantly better, in their opinion, as they may have better wages, because of the government wages based on predetermine standard (see Appendix VII), for all these situations.

The educational attainment of respondents showed that it influenced their opinions. For all three statements, those with Higher Degrees and First Degrees judged Contracted-out management not to be significantly better than Self-management.

Nationality did not influence the choice made by the respondents. The views of Saudis agreed with those of non-Saudis. For all three propositions, they all judged Contracted-out management not to be significantly better than Self-management.

So suggestions based on additional information have been made as to the reasoning behind these choices revealed in Tables 6.21, 6.24 and 6.25. However, there could be other non-quantifiable reasons for the opinions expressed by interviewees in the next chapter. These could be that in the particular hospital where the respondents work, regardless of the system of management, conditions could be favourable or unfavourable to them, as working conditions vary from one hospital to another, and may not be possible to relate them directly to the management system i.e. financial and human resources (Hannagan, 1995).

Therefore, looking overall at hospital management, it can be seen that most staff prefer in-house management to contracted-out management. This means that Hypothesis Two is rejected.

7.1 Management function: planning

The responsibility for planning cannot be separated from managerial performance because all managers plan and execute plans (Mookerjee, 1984). The major argument in favour of planning as a basic management function is that planning involves the co-ordination of decision-making, so that an organisation can move in a well-focused direction (Hannagan, 1995).

When interviewees were asked to comment on planning by their management, opinions were strongly weighted in favour of self-managed hospital systems as being better able to satisfy not only the hospital staff but also the government's aim, i.e. their main plan for the country's public health service: to retain expert staff, train nationals, reduce the cost of operations and to improve the national economy with improved health care.

Their main reason was that a self-managed system could plan long-term for medical services. As some interviewees who voiced their support for self-management expressed it: 'Self-management can plan for the future. Contracted-out management is a temporary measure - it is just for today, to solve a problem now. It is not concerned with future needs'. This view, though expressed in a different manner finds support from Hannagan (1995) and Harvey Jones (1995) among others.

Other reasons stated for considering planning under self-management to be more effective than contracted-out management were: 'With self-management the plans could progress more easily as there would be no disruption for contract issues, renegotiating terms and conditions etc.'. 'With self-management as a permanent system it would be easy to plan for future development and to train nationals in line with the government's policies' expressed in the Five Year Plans (4^{th}, 5^{th} and 6^{th}), i.e.

the Saudisation of the work force - make plans for introducing job training for Saudis; replace non-nationals with nationals for highly technical services.

Where self-management was replacing contracted-out management, "they [the managers] would be able to plan for terms and conditions of service and allow for a change-over period for when/if a new contractor takes over." There were many comments about the lack of planning in contracted-out management in cases where contractors had reneged on their agreements and chaos ensued until another took over. The time period of the contract may not allow staff to share their expertise with other employees who were in the organisation before. Thus, in the first year of the contract they are familiarising themselves with the previous management system. In the second year, they are ready to put into practice the necessary management improvements. In the final year, they are preparing to leave the organisation as there are no guarantees that the contract will be renewed until the contractual period is close to its finish. This gives little opportunity to build on improvements year by year.

Excuses for the contracted-out management included' ... very difficult to plan when you are not sure whether you will be dealing with the same people [contractor/ firm] next year or even in some cases three months time'. (Contracts are usually issued for three years but problems have been experienced with deficiencies in their work; payments to their staff either delayed or not forth-coming; and the contractor going out of business.)

However, "medical services need long-term plans" and "you have to plan for emergencies" were, also, frequent comments. Several people also stated that, in their experience, contracted-out management lacked 'reserve funds'. Five explained their remark by adding: "there is a need to plan for emergencies. The hospital [contracted-

out management] does not have money put aside which can be used immediately should an emergency occur. Having to wait until money can be found, or someone to take responsibility for finding the money can cause disruption across several departments due to having to get or borrow necessary equipment".

7.2 Management function: organising

The work of all organisations has to be organised and controlled. Once the process of implementation and action planning are agreed, managers have to organise the activities involved. Organising is the process of defining the tasks and activities to be carried out by a number of people to achieve particular objectives, whilst management control is the process of monitoring and adjusting these activities in order to achieve the greatest efficiency and effectiveness in meeting those objectives (Al-Numer, 1994). In other words, organising is deciding what is to be done and who is to do it.

About 30 managers / interviewees were very eager to express their opinions on the organisation of their management systems and/or how they could be improved. The main comments can be summed up as follows: 'There is a need to work within budgets [prior decided limits]"; "If you know what money is available, then you can tailor your needs to it, otherwise you can just get carried away and end up with several incomplete and inefficient or useless things".

There was an expressed need to promote the development of the skills of the staff, e.g. leadership skills, management skills and team work skills, and "to make staff aware that the manager will see that all stages of the work are carried out and will see it to completion" (see also Pincock, 1998). "Encourage national workers to train in the use of technical devices", and "Encourage departments to use new technology" were frequent comments.

There was stress on the need to introduce flexibility in working conditions: "I can only do that work in my department - this means that more people have to be employed than would be necessary if departments were inter-related work functions and, therefore, could help out in other departments if/when the need arose".

Delegating responsibility did not appear to be common, although it can help free managers to plan for work improvements and to train new supervisors (Al-Numer, 1994), Comments included: "Have a committee to take responsibility for supervising maintenance departments and purchasing new equipment"; "Encourage co-operation between senior staff so that they can recognise who is best at doing what and who can assume responsibility temporarily in a department other than his own" (see also Harvey Jones, 1995). "Encourage staff training so that present staff can progress to higher levels".

Various views were opined on how to improve the management of their hospitals so as to improve the efficiency and effectiveness of their organisation and to improve working conditions and stability of employment: "Job stability would promote loyalty - a sense of belonging"; "Liaise with similar departments in other hospitals".

In the opinion of many staff, contracted-out management "fails to monitor the work of contractors [delivering other services], which results in conflict between the supervisors and the contractors, which is time-wasting"; "When contractors are not properly supervised, deficiencies in carrying out maintenance can affect not only one department, but has repercussions in other parts of the hospital"; "Changes cannot be organised quickly".

7.3 Management function: directing

Directing involves guiding and leading subordinates, delegating tasks as necessary, dealing rapidly and efficiently with work crises and solving problems in regards to policy application and staff orientations (Vecchio, 1995; Muhana, 1998). The methods of directing may be of extraordinary complexity. The senior manager should inculcate in his subordinates a keen appreciation of enterprise traditions, history, objectives and policies (Hannagan, 1996). The manager's leadership style will influence the perception of the rewards available and what has to be achieved to earn them. The rewards may be in terms of pay and promotion, but will also include support, encouragement and recognition. Therefore, the interviewees were asked to discuss whether they considered that their managers had the necessary skill to solve the problems that arose in their hospital and to explain what the problems were.

Problems highlighted by interviewees either currently or formerly employed in contracted-out hospitals were mainly related to pay. There were many complaints about the low rates of pay for non-nationals and in some cases delays or the lack of pay altogether, where the contractors had gone into liquidation. In these cases, management control was thought to be lacking, and that with proper direction and leadership these situations would be dealt with quickly and successfully. There was an expressed belief that hospital self-management would solve these money problems.

It was stated that there was "a need to implement promotion schemes with adequate rewards" in both management systems"; "A good director would motivate people".

A lack of concern by hospital management for the well-being of the staff was expressed by Saudis working in contracted-out hospitals. Saudi staff considered that they were paid at lower rates than non-nationals with same qualifications, lacked the

opportunities for promotion, and were appreciated by neither the management nor by the non-national managers. On the other hand, in hospitals under both management systems, Asian and Southeast Asian workers considered that their working conditions and low rates of pay did not warrant attention from the management as was found by Hickson and Pugh (1995) in their study of conditions in Saudi Arabia and among Arabs, in general, in the Middle East.

The fact that few non-nationals speak Arabic, which is a hard language to learn, meant that communication between Saudis and non-Saudis caused problems (see Hickson and Pugh, 1996). As well as language difficulties, cultural differences confuse communication between patients and doctor, patient and nurse, receptionists and cleaners, etc., giving rise to resentment (ibid.). It is not easy to solve the problems that arise in relation to these factors, but blame is often attributed to management. Saudis may be more eager to work for a fellow countryman than a non-Saudi. There were a few opinions expressed that hospital self-management would ultimately result in general improvement for Saudis. On the other hand, some Saudis, as well as non-Saudis, were sceptical about the advantage of working for a Saudi manager: they "promote people who are relatives or friends, or friends of friends, regardless of their qualifications and training". Nepotism was considered to be the major drawback in having a Saudi manager.

7.4 Management function: controlling

Controlling means overseeing executives, measuring and correcting activities of subordinates so as to ensure that actions conform to plans (Saati, 1984; Al-Numer, 1994), making sure that it is done well, deciding who is responsible for each action and task, corrections are made to make sure that organisational aims are met.

Decisions have to be made about whether these actions and tasks should be carried out by departments, units or teams and assigning individuals to carry out these tasks. The lack of highly skilled management-trained supervisors can result in problems lower down, affecting the effectiveness and efficiency of the organisation (Hannagan, 1995). Therefore activities must be checked, and problems resolved before they get complicated, so that work activities are conducted smoothly concentrating on the hospital's basic purpose.

There were complaints about the lack of management skills and the way hospital directors were chosen frequently from medical staff, rather than trained managers with internationally-recognised management qualifications and training (Saaty 1998).

Other complaints were that the hospital was not channelling its resources into new technologies: "A computer should be a fixed item for every ward", and "We want skilled managers to be brought in to train some of our own staff to use new technology".

7.5 Management function: co-ordinating

Co-ordination is the integration of the activities of individuals and units into a concerted effort that works towards a common objective. This requires a well-understood chain of command and span of management (Hannagan, 1995). Management activity needs co-ordination between all its basic functions mentioned above, so that exchange of information, co-ordination and an open-door policy to get information feedback to the management staff allows work safety to be secured (Muhana, 1998). Of course, much will depend on the work to be co-ordinated and controlled. Managers vary in their management skills and leadership skills to manage a number of people. Frequently, as managers are promoted, their span of control

widens. In order to be effective managers, therefore, they need to be of a high quality management specialist. Pincock (1998) stated that, to counteract the negative effect of multi-national revolving door, Health Affairs needed to create an operating system that is operated and controlled by Saudi nationals and into which multi-national talent can be recruited. He also argued, that the Saudi leadership would achieve increased stability and derives a better sense of participation and direction.

The generally expressed opinion of the interviewees was that with contracted-out management, contrary to the situation in self-managed hospitals, there was no clear chain of command, e.g. "too many people in charge"; "lack of co-operation between departments"; "who is responsible for what is seldom clear"; "contracted firms are just in it for the money; they don't want the good of the hospital"; "they certainly don't co-operate with each other", etc.. However, there were comments which showed that in spite of what were regarded as their shortcomings, the necessity of having contractors to get the Health Service running and provide expert personnel (ex-patriots trained overseas) was recognised for their skills with lower wages. The difficulty of forming effective units when they were composed of Saudis and non-Saudis was expressed, but where Saudis had been trained overseas and there was no language (English) problem, difficulties were not considered insurmountable.

7.6 Summary

From the interviewees' comments, it could be ascertained that practically everyone had some complaint about their hospital's management. This is usual for any employee in any establishment. Introducing another management system can often be seen as the panacea for solving any problem real or imagined. Here, however, in the Saudi Arabian health system, is a situation which is not simply a case of private

versus public management, but one which is complicated due to the fact that a newly developed country, in terms of technology, experienced a sudden need to expand its health service for its people. For, due to oil revenues, there was not a lack of money for this venture, i.e. building, equipment and staffing hospitals and clinics. The main problem was where the necessary staff were to come from. Therefore, expatriate contracted management with their expatriate medical staff and technicians were brought in to run and staff the hospitals. Contracted firms are in the business of making profits, for without profits they would not exist. Within any one hospital there exist numerous sub-contractors and their staff who often fail to co-ordinate their work with that of other contractors. Saudi people resent foreigners running their hospitals, especially when many Saudis are now educated and trained (overseas) to do the work which formerly could be undertaken only by non-Saudis. The government actively encourages Saudisation of the workforce. So, there is encouragement for hospitals to become self-managed rather than to contract out the hospital management, since most of the local private sector have fewer Saudi personnel. Contracted-out management is dependent upon a multi-national workforce that produces a natural variation in the hospital system of services, creating unplanned, disjointed fluctuation, as skills, talent, ideas and expectations of the care providers changes over to another (Pincock, 1998).

The value of these interviews was to establish the views of the people both Saudi and non-Saudi who actually worked in the hospitals under both management systems.

From the results of the interviews it emerges that these staff members, from their own experience, consider the system of hospital self-management as the better means of running the country's health service in the future in order not only for it to fulfil its desired purpose but also as a better system under which to work.

Chapter Eight

Conclusion

This thesis tested two hypotheses:

1) There is no significant difference in management efficiency and effectiveness when the management is contracted-out or when the hospital is self-managed (in-house) in the case of the public health sector's hospital administration in Saudi Arabia.

2) Hospital staff, irrespective of their educational background and professional position, medical staff and nationality, support contracted-out management.

Many economists and business management specialists, especially in the West, consider private sector management to be the best form of management for public sector organisations. They hold that privatisation can improve the efficiency of public organisations management of an enterprise, as managers will have to deal with less bureaucracy and so will have more freedom to make independent flexible decisions; have less pressure put on them by politicians, and that owners may be viewed like shareholders (The NCB Economist, 1994).

These apparent advantages of private sector management were examined in the Saudi situation. It was noted that the history of Saudi Arabia in the twentieth century differs markedly from that of Europe and North America, giving Saudi Arabia issues to contend with not experienced, or not significant in Europe and the USA. A principal issue due to its only recent appearance on the industrial/high technology scene, is that Saudi Arabia did not have a reservoir of trained and skilled workers with which to resource the new industries and social developments, such as hospitals and clinics,

particularly once oil revenues enabled its public administration to fund vast planned developments. Therefore, Saudi Arabia needed quickly to purchase material goods, and to obtain a skilled workforce, from abroad. This resulted in an influx not only of highly skilled foreigners but, also, a vast number of semi-skilled and unskilled workers from Asia and South East Asia who were prepared to undertake, for wages in excess to those obtainable in their own countries, labouring and other menial work.

This influx of foreigners caused and causes resentment among nationals in three ways:

1) The foreign workers were not using their wages for the national economic benefit, but for themselves and for maintaining their families abroad;

2) They were of a different culture and, therefore, required the provision of different facilities to those of local people. There were also communication difficulties due to their lack of Arabic (Al-Nughimshi, 1998). So the need rose for recruitment of expert interpreters to act as mediators between patients and physicians, nurses and other non-Saudi staff, which in some cases lead to miscommunications, and thus, unsatisfactory service.

3) When nationals became educated and capable of performing highly skilled jobs opportunities for employment were not always available as foreign contractors brought in their own workforce were not keen to employ nationals as expatriates were often paid less than nationals by the private companies (Hickson and Pugh, 1995; Al-Gubaisi, 1997).

In the case of the above, the public administration, sought to remedy the situation by a Saudisation programme designed to replace non-Saudi staff with Saudis, and put

pressure on the private sector contractors to recruit Saudi for 5% of the skilled jobs and to train the unskilled Saudis and so this percentages will increase each year, confirmed by Council of Ministers order No. 50 (21/4/1415 H.) (Al-Dakhil, 1999).

Therefore, in order to test both hypotheses it was decided to collect relevant data by the use of questionnaires and where possible conduct interviews. The questionnaires were delivered to staff in the hospitals run under both management systems. An advantage from the point of view of the exercise was that some of these hospitals just had changed over from contracted-out management to self-managed, so that staff had experience of working under both management systems.

From the responses to the questionnaires, when the various management functions were evaluated it was found that neither system was considered as effective for all the forty variables (see Chapter 6). Those which tested management basic functions for the management planning, twelve variables (see Table 6.9) showed that the same for the first five variables were given positive response by both management systems. Only in one instance, 'written instructions for staff', was contracted-out management seen to be less efficient than self-managed. However, both systems were proved to be inadequate for several functions of variables including 'skilled Saudi staff', 'job stability' and 'retirement schemes'.

With management organising variables there was no significant difference in both management systems of the first five of the twelve variables (see Table 5.11). This left the same seven variables for each that showed inadequacies in management organising variables including Saudi technical skills and attendance at management conference.

For the management function termed 'Directing' (see Table 6.13), variables of the same first five out of twelve variables showed significant performance for both systems. The remaining seven for each system revealed poor performance on the part of the management, these of the lowest performance included 'Management conferences' 'Staff rewards' and 'Job promotion'.

Management control variables showed in both management systems to perform adequately for the same first five variables; 'Staff presence', 'Patient complaints', 'Skilled medical staff', 'Accuracy of laboratory results' and 'Quality control on medicare' (see Table 6.15). But, not as good as in the other variables, which are showied low performance under both management systems included the variable.

Both systems showed adequate performances in terms of job satisfaction for the same four of the twelve variables (Table 6.17), whereas eight variables revealed the need for attention on the part of their management efficiency.

So the first hypothesis, when judged from the answers to the questionnaires fails to be supported: no appreciable difference could be detected in the management styles of managers in Saudi public health hospitals with either contracted-out management or self-managed.

What is remarkable is that not only was there no significant difference between the estimation made by staff of both systems, but, also, that each system was considered satisfactory/adequate or unsatisfactory for the same variables.

Interviews on a one-to-one basis, as described in Chapter 4, were held in order to test whether staff, when in a more relaxed situation and answering open-ended questions, would enhance the views expressed in their questionnaires, or would provide different

answers when given time to assess the situation and, more importantly, could raise points which could be of value, which the interviewer questionnaire compiler had not envisaged.

When it comes to the results of the interviews, results were not the same. For management planning, self-managed hospitals were considered by the respondents to be better than hospitals with contracted-out management from the point of view of: job stability, progress of contract issues, retaining expert staff, renegotiating terms and conditions, direct relation with suppliers (see Chapter 7), and progress in Saudisation of the workforce. For organising by management, in the view of many staff, contracted-out management failed to monitor contractors and resolve disputes quickly so considerable time was wasted. The latter was considered by interviewees to be more easily dealt with in a self-managed system.

In directing the workforce, both management systems showed a lack of promotion prospects for workers which was for them a cause for concern. In the case of contracted-out management there were many comments about the insecurity of their jobs, in particular of failing to receive their wages owing to them. Contractors were often slow payers or even failed to pay their workers in full or not at all for few months (see Chapter 7). This is a serious fault, as the lack of adequate remuneration would, undoubtedly, lead to deterioration in their work performance, which, particularly in the case of a hospital, could endanger lives.

Controlling the activities of the hospital management to ensure that it was run satisfactorily proved difficult in the case of contracted-out management, as the continuity of the operations was constantly interrupted due to short term management contracts. This was considered to be the major problem by all the staff interviewed.

The introduction of an adequate changeover period would reduce disruption. The need for such a changeover period was discussed by several American writers, including Crawford and Krahn (1998), who favoured giving the privatisation of public services an adequate period for readjustment.

Job satisfaction was considered better or believed to be better under self-management, mainly because job stability management is in the hands of permanent staff rather than a variety of changeover contractors. A clear chain of command promotes confidence for the workforce (Hannagan, 1995).

When examining all the recorded statements of the staff in both the contracted-out management and self-managed system, the self-management was deemed to be better for job satisfaction than contracted-out management for a variety of reasons (see Chapter 6). Whether the expressed opinions can be taken as an accurate picture of the true situation is difficult to estimate. Both Hannagan (1995) and Harvey Jones (1995) refer to the fact that attitudes of staff towards their managers could have as much to do with the personality and competence of the managing director as with the actual system of management. This is a strong argument for having on adequately trained manager. However, it is a fact of life that staff in any system of management will have grumbles about their managers. There is always a 'boss and workers' attitude (see Harvey Jones, 1995).

The interviewees were aware that both management systems needed to pay attention to particular aspects of their management basic functions including promoting the staff's job satisfaction. Higher levels of the satisfaction variables, for the twelve variables tested, were achieved in only a maximum of six on one occasion only, and in all other cases only four or five (see Chapter 7).

Therefore, the second hypothesis cannot be supported, i.e. contracted-out management was not found to be preferable to self-management from the staff's point of view (see Chapters 6, section 6.3).

The evidence presented in this thesis has failed to support either hypothesis, and gives weight to Elcock's contention that the application of commercial management values can damage 'the collective public interest' (1995:39). In the context of public services, as Hemming and Mansoor (1988), Hannagan (1995) and Elcock (1995) pointed out, management cannot be restricted to the three 'Es' - economy, efficiency and effectiveness.

The value of this thesis to future development of the Saudi health service lies in the fact that it explains why the contracting-out of management to private sector companies is not the best way of running government hospitals in Saudi Arabia. In order for the public health management services to satisfy the socio-cultural and physical needs of its citizens it must be seen to be their health service (Viola, 1986). This does not mean that it should ignore the experiences of other countries with similar problems and modern management practices, as it must take on board the need for effective and efficient managers to run the hospitals. Future research into the effects of changing from contracted-out management to self-management would be invaluable to the future of the Saudi health service.

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Appendix I: Questionnaires in English

Dear Participant:

This questionnaire is part of my academic research towards completion Ph.D. in Public Administration from the Center for Middle Eastern and Islamic Studies, University of Durham, UK.

Your response to this questionnaire will be highly valuable, and will not to be published. It will be strictly confidential, and will only be used for the purpose of the study, knowing that you do not need to mention your name.

So, please indicate to what you actually observe at your work by putting an [X] in a box which indicates your agreed measurement's degree for each statement.

Thank you for taking the initiative in filling this questionnaire today and send it to:

Mr. Shabbab A. Al_Harthi

King Khalid Military Academy

Riyadh, K.S.A.

No	Statements	Always	Most of the times	Sometime	Seldom	Never
1	My department objectives are clear.	❑	❑	❑	❑	❑
2	Work procedures are clear.	❑	❑	❑	❑	❑
3	I care about cost containment at work.	❑	❑	❑	❑	❑
4	My job responsibilities are clear.	❑	❑	❑	❑	❑
5	My immediate supervisor takes the right decision at reasonable time.	❑	❑	❑	❑	❑
6	I receive managerial instructions in a written form.	❑	❑	❑	❑	❑
7	The management rewards outstanding performance.	❑	❑	❑	❑	❑
8	My job promotions have proved satisfactory.	❑	❑	❑	❑	❑
9	I feel that my job is stable.	❑	❑	❑	❑	❑
10	Job description for my position is clear.	❑	❑	❑	❑	❑
11	In my department, Saudi staffs hold key positions.	❑	❑	❑	❑	❑
12	My department has Saudi Technical staff working on technological equipment.	❑	❑	❑	❑	❑
13	In my department, staff participates in the decision making process.	❑	❑	❑	❑	❑
14	The management insists on staff presence during all working hours.	❑	❑	❑	❑	❑
15	To modify work procedures is easy.	❑	❑	❑	❑	❑
16	The departmental management has an open-door policy for complaints and suggestions.	❑	❑	❑	❑	❑
17	My department discusses staff's performance evaluations.	❑	❑	❑	❑	❑
18	My department holds meetings to discuss performance improvements.	❑	❑	❑	❑	❑
19	My departmental management implements Quality Control Management system.	❑	❑	❑	❑	❑
20	The hospital has a Quality Control Management system over medical applications.	❑	❑	❑	❑	❑
21	Equipment maintenance is appropriate.	❑	❑	❑	❑	❑
22	Hospital nursing staffs are qualified.	❑	❑	❑	❑	❑
23	The administration gives me a chance to attend meetings & conferences of management.	❑	❑	❑	❑	❑

No	Statements	Always	Most of the times	Sometime	Seldom	Never
24	The management gives the chance to attend meetings & conferences of my specialty.	❑	❑	❑	❑	❑
25	In my opinion, the laboratory results at this hospital are accurate.	❑	❑	❑	❑	❑
26	Requirements for recruitment for positions are clearly defined.	❑	❑	❑	❑	❑
27	Medical staff's skills are satisfactory.	❑	❑	❑	❑	❑
28	Recruitment priority has been giving to qualified personnel.	❑	❑	❑	❑	❑
29	My department recruits qualified Saudis.	❑	❑	❑	❑	❑
30	Nutrition services are well performed.	❑	❑	❑	❑	❑
31	The hospital offers a good pension scheme.	❑	❑	❑	❑	❑
32	Patient's complaints are taken into consideration.	❑	❑	❑	❑	❑
33	The departmental equipments are appropriate for the job.	❑	❑	❑	❑	❑
34	The hospital takes advantage of medical communication technology.	❑	❑	❑	❑	❑
35	My department has close contact with other hospital departments for exchange of experience.	❑	❑	❑	❑	❑
36	The hospital constantly adds new health services.	❑	❑	❑	❑	❑
37	Total Quality Management department performs effectively.	❑	❑	❑	❑	❑
38	The emergency department procedures are rapid.	❑	❑	❑	❑	❑
39	The hospital carryout special programmes to increase health awareness.	❑	❑	❑	❑	❑
40	The hospital keeps clean	❑	❑	❑	❑	❑
41	Contracted management is rather better than Self-managed for all services, **apart from** medical service.	❑	❑	❑	❑	❑
42	Contracted management is rather better than Self-managed for managing the **medical service**.	❑	❑	❑	❑	❑
43	Contracted management is rather better than Self-managed for **all services**, including medical services.	❑	❑	❑	❑	❑

- If you have any comments relating the improvement of the hospital management services, please state below and continue overleaf if necessary: ----------

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Background information

1- Gender:

❑ Male ❑ Female

2- Age:

❑ 20-30 ❑ 31-40 ❑ 41-50

❑ 51-60 ❑ 61- or more

3- Position:

❑ Director or Manager

❑ Management Staff or Clerk

❑ physician & Medical staff

4- Years of experience in this present position:

❑ Less than 3 years. ❑ 3 - 6 years

❑ 7 – 10 years ❑ more than10 years

5- Years of experience in this Organisation:

❑ Less than 3 years. ❑ 3 - 6 years

❑ 7 – 10 years ❑ more than10 years

6- Education:

❑ Secondary or less ❑ Bachelor of Art ❑ Bachelor of Science

❑ Master in Art ❑ Master in Science ❑ Doctorate in Art

❑ Doctorate in Science ❑ Other Degrees in .....

7- How long you have been in other Organizations?

❑ Less than 3 years ❑ 3 - 6 years

❑ 7 – 10 years ❑ more than10 years

8- Nationality:

❑ Saudi ❑ Non-Saudi

9- Employed by:

❑ Public Sector ❑ Private sector (Contractor) ❑ Hospital Project

Appendix II Survey Questionnaires in Arabic

May,18th /99.
– مايو –

بسم الله الرحمن الرحيم

عزيزي المشارك

السلام عليكم ورحمة الله وبركاته

هذا الاستبيان جزء رئيسي من دراستي للحصول على درجة الدكتوراة في تخصص الإدارة العامة من مركز دراسات الشرق الأوسط والدراسات الإسلامية، بجامعة درم، بالمملكة المتحدة.

إن إجابتك على هذا الاستبيان سوف تكون ذات قيمة بالغة في إنجاح أهداف هذه الدراسة.علماً بأن ذكر الاسم غير مطلوب، وأن هذه المعلومات غير قابلة للنشر وسوف تعامل بسرية تامة لغرض هذه الدراسة فقط.

لذا يُرجى التكرم بأن تُشير إلى ما تراه بالفعل بوضع علامة (x) في المربع الذي يبين درجة موافقتكم لكل عبارة.

شاكرين حسن تعاونكم بتعبئة هذا الاستبيان اليوم والمبادرة بإرساله إلى:

الباحث/ شباب بن عويض الحارثي
كلية الملك خالد العسكرية
الرياض /المملكة العربية السعودية

Questionnaire

Dear Participant:

This questionnaire is part of my academic research towards completion Ph.D. in Public Administration from the Centre for Middle Eastern and Islamic Studies, University of Durham, UK.

Your response to this questionnaire will be highly valuable, and will not to be published. It will be strictly confidential, and will only be used for the purpose of the study , knowing that you do not need to mention your name.

So, please indicate to what you actually observe at your work by putting an [x] in a box which indicates your agreed measurement's degree for each statement.

Thank you for taking the initiative in filling this questionnaire today and send it to:

Mr. Shabbab Al Harthi

King Khalid Military Academy
Riyadh, KSA.

عدد	ا لعبارات	دائماً	غالباً	أحياناً	نادراً	أبداً
–	أهداف القسم الذي أعمل به واضحة.	❑	❑	❑	❑	❑
	إجراءات العمل بالقسم الذي أعمل به واضحة.	❑	❑	❑	❑	❑
	أهتم بتقليل التكاليف في أداء العمل.	❑	❑	❑	❑	❑
	لدي فكرة واضحة تجاه مسؤوليات عملي.	❑	❑	❑	❑	❑
	مديري المباشر يتخذ القرار المناسب في الوقت المناسب.	❑	❑	❑	❑	❑
	التعليمات الإدارية تصل إليَ بشكل مكتوب.	❑	❑	❑	❑	❑
	الإدارة تكافئ العاملين ذوي الأداء المتميز.	❑	❑	❑	❑	❑
	ترقياتي الوظيفية في هذا المستشفى مرضية.	❑	❑	❑	❑	❑
	أ شعر بالاستقرار الوظيفي في هذه المؤسسة.	❑	❑	❑	❑	❑
ž–	لدى القسم كوادر سعودية تقوم بمهام القسم.	❑	❑	❑	❑	❑
—	الوصف الوظيفي لعملي بالقسم واضح.	❑	❑	❑	❑	❑
–	لدى القسم كوادر سعودية تعمل على أجهزة القسم.	❑	❑	❑	❑	❑
–	العاملين بالقسم يشاركون في عملية اتخاذ القرار.	❑	❑	❑	❑	❑
–	الإدارة تحرص على تواجد العاملين أثناء ساعات العمل.	❑	❑	❑	❑	❑
–	من السهل إعادة صياغة إجراءات العمل للتسهيل.	❑	❑	❑	❑	❑
–	الإدارة تطبق سياسة الباب المفتوح لتقبل الشكاوي والاقتراحات.	❑	❑	❑	❑	❑
–	تقوم إدارة القسم بعمل اجتماعات لمناقشة تقييم الأداء.	❑	❑	❑	❑	❑
–	تقوم إدارة القسم بعمل اجتماعات لمناقشة الأمور المرتبطة بتحسين الأداء.	❑	❑	❑	❑	❑
–	إدارة القسم لديها نظام لمراقبة جودة الأداء.	❑	❑	❑	❑	❑
–	صيانة الأجهزة تتم على مستوى مناسب.	❑	❑	❑	❑	❑
	أعضاء هيئة التمريض ذوا كفاءة.	❑	❑	❑	❑	❑
	الإدارة تعطي لي الفرصة لحضور الاجتماعات و المؤتمرات الخاصة بالتطوير الإداري.	❑	❑	❑	❑	❑
	يوجد بالمستشفى نظام رقابي لمتابعة الجودة الطبية.	❑	❑	❑	❑	❑

عدد	ا لعبارات	دائماً	غالباً	أحياناً	نادراً	أبداً
	الإدارة تسمح لي بحضور الاجتماعات والمؤتمرات المتعلقة بتخصصي.	❑	❑	❑	❑	❑
	في رأيي أن نتائج التحاليل الطبية بهذا المستشفى دقيقة.	❑	❑	❑	❑	❑
	أنظمة التعيين في هذا المستشفى واضحة لكل وظيفة.	❑	❑	❑	❑	❑
	مهارة الأطباء بالمستشفى على مستوى مرضي.	❑	❑	❑	❑	❑
	أنظمة التعيين تركز على الكفاءة.	❑	❑	❑	❑	❑
ž	تركز إدارة القسم على توظيف الكوادر الوطنية.	❑	❑	❑	❑	❑
–	خدمات التغذية بالمستشفى جيدة الأداء.	❑	❑	❑	❑	❑
	لدى المستشفى نظاماً جيد لمعاشات التقاعد.	❑	❑	❑	❑	❑
	الإدارة تأخذ بشكاوي المرضى بالاعتبار.	❑	❑	❑	❑	❑
	أجهزة القسم الذي أعمل به قائمة بمتطلبات العمل.	❑	❑	❑	❑	❑
—	المستشفى يستفيد من تكنولوجيا الاتصالات الطبية.	❑	❑	❑	❑	❑
	إدارة القسم تتصل بأقسام المستشفيات الحكومية الأخرى من أجل تبادل الخبرات.	❑	❑	❑	❑	❑
37	المستشفى يضيف باستمرار خدمات صحية.	❑	❑	❑	❑	❑
38	قسم إدارة الجودة الشاملة له أداء فعال.	❑	❑	❑	❑	❑
39	المستشفى يتميز بسرعة الإجراء في قسم الطوارئ.	❑	❑	❑	❑	❑
30	إدارة المستشفى تقوم بإعداد برامج خاصة لزيادة الوعي الصحي بالمجتمع.	❑	❑	❑	❑	❑
40	يتميز المستشفى بالمحافظة على النظافة.	❑	❑	❑	❑	❑
41	القطاع الخاص أفضل من القطاع العام في إدارة وتشغيل جميع الخدمات غير الطبية بكفاءة.	❑	❑	❑	❑	❑
42	القطاع الخاص أفضل من القطاع العام في إدارة وتشغيل الخدمات الطبية بكفاءة.	❑	❑	❑	❑	❑
43	القطاع الخاص أفضل من القطاع العام بتشغيل جميع الخدمات بالمستشفى بكفاءة.	❑	❑	❑	❑	❑

- وأي اقتراح من شأنه تطوير إدارة خدمات المستشفى، من فضلك أذكر ذلك خلف الصفحة ~

Background information

1- Gender:

❑ Male ❑ Female

2- Age:

❑ 20-30 ❑ 31-40 ❑ 41-50

❑ 51-60 ❑ 61- or more

3- Position:

❑ Director or Manager

❑ Management Staff or Clerk

❑ Physician & Medical staff

4- Years of experience in this present position:

❑ Less than 3 years. ❑ 3 - 6 years

❑ 7 – 10 years ❑ more than10 years

5- Years of experience in this Organisation:

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❑ 7 – 10 years ❑ more than10 years

6- Education:

❑ Secondary or less ❑ Bachelor of Art ❑ Bachelor of Science

❑ Master in Art ❑ Master in Science ❑Doctorate in Art

❑ Doctorate in Science ❑Other Degrees in .....

7- How long you have been in other Organizations?

❑ Less than 3 years ❑ 3 - 6 years

❑ 7 – 10 years ❑ more than10 years

8- Nationality:

❑ Saudi ❑ Non- Saudi

9- Employed by:

❑ Public Sector ❑ Private sector (Contractor) ❑ Hospital Project

Appendix III: Interductory Letter from the Commander of King Khalid Military Academy

KINGDOM OF SAUDIA ARABIA
NATIONAL GUARD
KING KHALID MILITARY ACADEMY

Ref:
Date: 30/5/1418H
Subj:

His Excellency/ the Counselor and chief executive of administration affairs and the executive director of Al-Imaan Hospital in Riyadh

Assalam Alaykom Warahmat Allah Wabarakatuh (Greetings);

The lecturer/ Shabbab Awaidh Al- Harthi is a member of the academic staff at King Khalid Military Academy. He is now on a research fieldwork to complete the degree of Ph.D. in Public Administration. This fieldwork survey, which is related to the Contracted-out management in public administration, is one of the major concerns of this research.

In order to get the point of views of the administrative staff in this hospital with regard to this important and vital issue. Therefore, we would be pleased if you could co-ordinate and direct whom it may concern to co-operate and make it easy for the researcher to fulfill his mission which we hope will accomplish its desired objectives.

Yours sincerely

General/ Mut'ib bin Abdullah bin Abdul Aziz
Commander of King Khalid Military Academy

Appendix III: Interductory Letter from the Commander of King Khalid Military Academy

KINGDOM OF SAUDIA ARABIA
NATIONAL GUARD
KING KHALID MILITARY ACADEMY

Ref:
Date: 30/5/1418H
Subj:

His Excellency/ the Counselor and chief executive of administration affairs and the executive director of Al-Amal Hospital in Dammam

Assalam Alaykom Warahmat Allah Wabarakatuh (Greetings);

The lecturer/ Shabbab Awaidh Al- Harthi is a member of the academic staff at King Khalid Military Academy. He is now on a research fieldwork to complete the degree of Ph.D. in Public Administration. This fieldwork survey, which is related to the Contracted-out management in public administration, is one of the major concerns of this research.

In order to get the point of views of the administrative staff in this hospital with regard to this important and vital issue. Therefore, we would be pleased if you could co-ordinate and direct whom it may concern to co-operate and make it easy for the researcher to fulfill his mission which we hope will accomplish its desired objectives.

Yours sincerely

General/ Mut'ib bin Abdullah bin Abdul Aziz
Commander of King Khalid Military Academy

Appendix III: Interductory Letter from the Commander of King Khalid Military Academy (in English)

KINGDOM OF SAUDIA ARABIA
NATIONAL GUARD
KING KHALID MILITARY ACADEMY

Ref:
Date: 30/5/1418H
Subj:

His Excellency/ the Counselor and chief executive of administration affairs and the executive director of King Faisal Specialist Hospital and Research Centre

Assalam Alaykom Warahmat Allah Wabarakatuh (Greetings);

The lecturer/ Shabbab Awaidh Al- Harthi is a member of the academic staff at King Khalid Military Academy. He is now on a research fieldwork to complete the degree of Ph.D. in Public Administration. This fieldwork survey, which is related to the Contracted-out management in public administration, is one of the major concerns of this research.

In order to get the point of views of the administrative staff in this hospital with regard to this important and vital issue. Therefore, we would be pleased if you could co-ordinate and direct whom it may concern to co-operate and make it easy for the researcher to fulfill his mission which we hope will accomplish its desired objectives.

Yours sincerely

General/ Mut'ib bin Abdullah bin Abdul Aziz
Commander of King Khalid Military Academy

KINGDOM OF SAUDIA ARABIA
NATIONAL GUARD
KING KHALID MILITARY ACADEMY

Ref:
Date: 30/5/1418H
Subj:

His Excellency/ the Counselor and chief executive of administration affairs and the executive director of King Faisal Specialist Hospital and Research Centre

Assalam Alaykom Warahmat Allah Wabarakatuh (Greetings);

The lecturer/ Shabbab Awaidh Al- Harthi is a member of the academic staff at King Khalid Military Academy. He is now on a research fieldwork to complete the degree of Ph.D. in Public Administration. This fieldwork survey, which is related to the Contracted-out management in public administration, is one of the major concerns of this research.

In order to get the point of views of the administrative staff in this hospital with regard to this important and vital issue. Therefore, we would be pleased if you could co-ordinate and direct whom it may concern to co-operate and make it easy for the researcher to fulfill his mission which we hope will accomplish its desired objectives.

Yours sincerely

General/ Mut'ib bin Abdullah bin Abdul Aziz
Commander of King Khalid Military Academy

KINGDOM OF SAUDIA ARABIA
NATIONAL GUARD
KING KHALID MILITARY ACADEMY

Ref:
Date: 30/5/1418H
Subj:

His Excellency/ the Counselor and chief executive of administration affairs and the executive director of Al-Amal Hospital in Dammam

Assalam Alaykom Warahmat Allah Wabarakatuh (Greetings);

The lecturer/ Shabbab Awaidh Al- Harthi is a member of the academic staff at King Khalid Military Academy. He is now on a research fieldwork to complete the degree of Ph.D. in Public Administration. This fieldwork survey, which is related to the Contracted-out management in public administration, is one of the major concerns of this research.

In order to get the point of views of the administrative staff in this hospital with regard to this important and vital issue. Therefore, we would be pleased if you could co-ordinate and direct whom it may concern to co-operate and make it easy for the researcher to fulfill his mission which we hope will accomplish its desired objectives.

Yours sincerely

General/ Mut'ib bin Abdullah bin Abdul Aziz
Commander of King Khalid Military Academy

KINGDOM OF SAUDIA ARABIA
NATIONAL GUARD
KING KHALID MILITARY ACADEMY

Ref:
Date: 30/5/1418H
Subj:

His Excellency/ the Counselor and chief executive of administration affairs and the executive director of Al-Imaan Hospital in Riyadh

Assalam Alaykom Warahmat Allah Wabarakatuh (Greetings);

The lecturer/ Shabbab Awaidh Al- Harthi is a member of the academic staff at King Khalid Military Academy. He is now on a research fieldwork to complete the degree of Ph.D. in Public Administration. This fieldwork survey, which is related to the Contracted-out management in public administration, is one of the major concerns of this research.

In order to get the point of views of the administrative staff in this hospital with regard to this important and vital issue. Therefore, we would be pleased if you could co-ordinate and direct whom it may concern to co-operate and make it easy for the researcher to fulfill his mission which we hope will accomplish its desired objectives.

Yours sincerely

General/ Mut'ib bin Abdullah bin Abdul Aziz
Commander of King Khalid Military Academy

KINGDOM OF SAUDIA ARABIA
NATIONAL GUARD
KING KHALID MILITARY ACADEMY

Ref:
Date: 30/5/1418H
Subj:

His Excellency/ the Counselor and chief executive of administration affairs and the executive director of King Saud Hospital in 'Unayzah

Assalam Alaykom Warahmat Allah Wabarakatuh (Greetings);

The lecturer/ Shabbab Awaidh Al- Harthi is a member of the academic staff at King Khalid Military Academy. He is now on a research fieldwork to complete the degree of Ph.D. in Public Administration. This fieldwork survey, which is related to the Contracted-out management in public administration, is one of the major concerns of this research.

In order to get the point of views of the administrative staff in this hospital with regard to this important and vital issue. Therefore, we would be pleased if you could co-ordinate and direct whom it may concern to co-operate and make it easy for the researcher to fulfill his mission which we hope will accomplish its desired objectives.

Yours sincerely

General/ Mut'ib bin Abdullah bin Abdul Aziz
Commander of King Khalid Military Academy

KINGDOM OF SAUDIA ARABIA
NATIONAL GUARD
KING KHALID MILITARY ACADEMY

Ref:
Date: 30/5/1418H
Subj:

His Excellency/ the Counselor and chief executive of administration affairs and the executive director of Prince Abdullah Hospital in Bishah

Assalam Alaykom Warahmat Allah Wabarakatuh (Greetings);

The lecturer/ Shabbab Awaidh Al- Harthi is a member of the academic staff at King Khalid Military Academy. He is now on a research fieldwork to complete the degree of Ph.D. in Public Administration. This fieldwork survey, which is related to the Contracted-out management in public administration, is one of the major concerns of this research.

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Commander of King Khalid Military Academy

KINGDOM OF SAUDIA ARABIA
NATIONAL GUARD
KING KHALID MILITARY ACADEMY

Ref:
Date: 30/5/1418H
Subj:

His Excellency/ the Counselor and chief executive of administration affairs and the executive director of the Armed Forces Hospital in Riyadh

Assalam Alaykom Warahmat Allah Wabarakatuh (Greetings);

The lecturer/ Shabbab Awaidh Al- Harthi is a member of the academic staff at King Khalid Military Academy. He is now on a research fieldwork to complete the degree of Ph.D. in Public Administration. This fieldwork survey, which is related to the Contracted-out management in public administration, is one of the major concerns of this research.

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Commander of King Khalid Military Academy

KINGDOM OF SAUDIA ARABIA
NATIONAL GUARD
KING KHALID MILITARY ACADEMY

Ref:
Date: 30/5/1418H
Subj:

His Excellency/ the Executive director of Health Affairs in the National Guards

Assalam Alaykom Warahmat Allah Wabarakatuh (Greetings);

The lecturer/ Shabbab Awaidh Al- Harthi is a member of the academic staff at King Khalid Military Academy. He is now on a research fieldwork to complete the degree of Ph.D. in Public Administration. This fieldwork survey, which is related to the Contracted-out management in public administration, is one of the major concerns of this research.

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General/ Mut'ib bin Abdullah bin Abdul Aziz
Commander of King Khalid Military Academy

KINGDOM OF SAUDIA ARABIA
NATIONAL GUARD
KING KHALID MILITARY ACADEMY

Ref:
Date: 30/5/1418H
Subj:

His Excellency/ the Counselor of King Abdul Aziz Hospital in Jeddah

Assalam Alaykom Warahmat Allah Wabarakatuh (Greetings);

The lecturer/ Shabbab Awaidh Al- Harthi is a member of the academic staff at King Khalid Military Academy. He is now on a research fieldwork to complete the degree of Ph.D. in Public Administration. This fieldwork survey, which is related to the Contracted-out management in public administration, is one of the major concerns of this research.

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Yours sincerely

General/ Mut'ib bin Abdullah bin Abdul Aziz
Commander of King Khalid Military Academy

KINGDOM OF SAUDIA ARABIA
NATIONAL GUARD
KING KHALID MILITARY ACADEMY

Ref:
Date: 30/5/1418H
Subj:

His Excellency/ the Counselor of Maternity and Child Hospital in Al-Ahsaa'

Assalam Alaykom Warahmat Allah Wabarakatuh (Greetings);

The lecturer/ Shabbab Awaidh Al- Harthi is a member of the academic staff at King Khalid Military Academy. He is now on a research fieldwork to complete the degree of Ph.D. in Public Administration. This fieldwork survey, which is related to the Contracted-out management in public administration, is one of the major concerns of this research.

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Yours sincerely

General/ Mut'ib bin Abdullah bin Abdul Aziz
Commander of King Khalid Military Academy

KINGDOM OF SAUDIA ARABIA
NATIONAL GUARD
KING KHALID MILITARY ACADEMY

Ref:
Date: 30/5/1418H
Subj:

His Excellency/ Director of Security Forces Hospital

Assalam Alaykom Warahmat Allah Wabarakatuh (Greetings);

The lecturer/ Shabbab Awaidh Al- Harthi is a member of the academic staff at King Khalid Military Academy. He is now on a research fieldwork to complete the degree of Ph.D. in Public Administration. This fieldwork survey, which is related to the Contracted-out management in public administration, is one of the major concerns of this research.

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Yours sincerely

General/ Mut'ib bin Abdullah bin Abdul Aziz
Commander of King Khalid Military Academy

KINGDOM OF SAUDIA ARABIA
NATIONAL GUARD
KING KHALID MILITARY ACADEMY

Ref:
Date: 30/5/1418H
Subj:

His Excellency/ the Counselor of King Khalid Eye-Specialist Hospital

Assalam Alaykom Warahmat Allah Wabarakatuh (Greetings);

The lecturer/ Shabbab Awaidh Al- Harthi is a member of the academic staff at King Khalid Military Academy. He is now on a research fieldwork to complete the degree of Ph.D. in Public Administration. This fieldwork survey, which is related to the Contracted-out management in public administration, is one of the major concerns of this research.

In order to get the point of views of the administrative staff in this hospital with regard to this important and vital issue. Therefore, we would be pleased if you could co-ordinate and direct whom it may concern to co-operate and make it easy for the researcher to fulfill his mission which we hope will accomplish its desired objectives.

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General/ Mut'ib bin Abdullah bin Abdul Aziz
Commander of King Khalid Military Academy